

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
13446
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13406

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4yrs5mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dennis Middle Adams Last Adams		4. DATE OF DEATH 12 - 10 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1875
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter and blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscl. Cardiovasc. Disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general, severe DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 2, 1960 to 12/10 , 19 60 , that (I) (we) last saw the deceased alive on 12/10 , 19 60 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) STELLA WACHSLER		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-13-60		23b. DATE THEREOF 12-13-60	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cem		23d. LOCATION (City, town, or county) (State) Waldorf, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		25a. REC'D BY REGISTRAR DEC 15 '60	
ADDRESS Waldorf Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13447 CERTIFICATE OF DEATH

13407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		d. STREET ADDRESS 328 S. Oldham Street	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle J. Last ADEY		4. DATE OF DEATH Month December Day 11 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 73 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? 10 min	
13. FATHER'S NAME George Pierman		14. MOTHER'S MAIDEN NAME Johanna Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 607 S. Newkirk Street	
17. INFORMANT Harry W. Adey		Address 607 S. Newkirk Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalis DUE TO (c) Age			INTERVAL BETWEEN ONSET AND DEATH 10 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/14 , 19 60 , to 12/11 , 19 60 , that I last saw the deceased alive on 12/5 , 19 60 , and that death occurred at 9:54 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Curt Rauter		M.D. 4605 EDMONDSON AVE 12/12/60	
PHYSICIAN'S NAME (Type) C. L. R. RUTLIFE, JR.		BALTIMORE 29, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-14-1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 1901 Eastern Avenue		24. REC'D BY REGISTRAR DATE DEC 13 '60	
24b. REGISTRAR'S SIGNATURE Arthur J. Kraus			

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE 18

18447

REG. DIST. NO.

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Sex]</p>	
<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>	
<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. OCCUPATION [Occupation]</p>	
<p>7. MARITAL STATUS [Marital status]</p>		<p>8. CAUSE OF DEATH [Cause of death]</p>	
<p>9. DATE OF DEATH [Date of death]</p>		<p>10. TIME OF DEATH [Time of death]</p>	
<p>11. PLACE OF DEATH [Place of death]</p>		<p>12. SIGNATURE OF DECEASED [Signature of deceased]</p>	
<p>13. SIGNATURE OF WITNESS [Signature of witness]</p>		<p>14. SIGNATURE OF PHYSICIAN [Signature of physician]</p>	
<p>15. SIGNATURE OF CLERK [Signature of clerk]</p>		<p>16. SIGNATURE OF REGISTRAR [Signature of registrar]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13448

CERTIFICATE OF DEATH

Reg. Dist. No.

13408

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington			
				d. STREET ADDRESS 1219 Lake Ave.			
3. NAME OF DECEASED (Type or print) William A. Akehurst				4. DATE OF DEATH Dec. 9..1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7-1886	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Akehurst				14. MOTHER'S MAIDEN NAME Margaret Naylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Florence E. Akehurst Address Baltimore 9. Md. 1219 Lake Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic C.V. Dis. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11/1/59, 1960 , to 12/9, 1960 , that I last saw the deceased alive on 12/9, 1960 , and that death occurred at 10:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4037 Falls Rd. DATE SIGNED 12/10/60 ACTUAL SIGNATURE Edward H. Hossman M.D. PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/60		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge CEM.		22d. LOCATION (City, town, or county) (State) Pikesville, Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Seitz ADDRESS 814 W 36th St				24a. REC'D BY REGISTRAR DATE DEC 13 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Fries	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. CITY OF BIRTH [REDACTED]		7. STATE OF BIRTH [REDACTED]		8. COUNTRY OF BIRTH [REDACTED]	
9. OCCUPATION [REDACTED]		10. MARITAL STATUS [REDACTED]		11. DATE OF MARRIAGE [REDACTED]		12. DATE OF DEATH [REDACTED]	
13. CAUSE OF DEATH [REDACTED]		14. MANNER OF DEATH [REDACTED]		15. PLACE OF DEATH [REDACTED]		16. CITY OF DEATH [REDACTED]	
17. COUNTY OF DEATH [REDACTED]		18. STATE OF DEATH [REDACTED]		19. COUNTRY OF DEATH [REDACTED]		20. DATE OF DEATH [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]		23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]		27. SIGNATURE OF DECEASED [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]		31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]		35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]		39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]		43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]	
45. SIGNATURE OF DECEASED [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]		47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]		51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]		55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]	
57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF WITNESS [REDACTED]		59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]		63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]		67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]	
69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]		71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]		75. SIGNATURE OF DECEASED [REDACTED]		76. SIGNATURE OF WITNESS [REDACTED]	
77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]		79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]		83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]		87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF WITNESS [REDACTED]	
89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]		91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]		95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

13430 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13409

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8043 E. Baltimore Street				d. STREET ADDRESS 1 8043 E. Baltimore Street			
3. NAME OF DECEASED (Type or print) First Middle Last DOLORES C. ALLAN (ALLEN)				4. DATE OF DEATH Month Day Year December 20 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 1-1935-25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARK PLAZA HOTEL		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Michael				14. MOTHER'S MAIDEN NAME Josephine MANCUSO			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address MR Eugene L. ALLAN SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab Wounds of Chest. DUE TO (b) 982X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation.			
20c. TIME OF INJURY Month, Day, Year 10:30 PM 12/20 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Dundalk Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty				DATE SIGNED 12/20/60			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-24-60				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer				22d. LOCATION (City, town, or country) (State) BALTIMORE - Md			
23. FUNERAL DIRECTOR Leonard J. Ruck				24a. REC'D BY REGISTRAR DEC 27 '60			
ADDRESS 5305 HARTFORD				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

10410

(3480) MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
OF NEW YORK

Baltimore

Baltimore

Baltimore

Female

Female

BOY, J., Baltimore Street, Baltimore

BOY, J., Baltimore Street, Baltimore

1900

December 20

DECEASED (FATHER)

DECEASED

25

White

Female

Step-son of the

Deceased during

Baltimore

Baltimore

Male

Male

1900

X

X

X

1900

Charles J. Fox, M.D.

1

13449

13410

13449

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 1yr. 3mths 10d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Joseph Last Anton		4. DATE OF DEATH Month 12 Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-82
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHIRT CUTTER		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) M.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT RECORDS : SPRING GROVE STATE HOSP		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4 9 3 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (p) CHRONIC BRAINS SYNDROME ASS. & CEREBRAL ARTERIO SCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-24 , 19 60 , to 12-24 , 19 60 , that I last saw the deceased alive on 12-24-60 , 19 60 , and that death occurred at 10:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jose R. Arizaga M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSP. DATE SIGNED	
PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA		CATONSVILLE 2P, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/28/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) BALTIMORE Md	
23. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck ADDRESS 5305 HARFORD Rd.		24a. REC'D BY REGISTRAR DEC 28 '60 24b. REGISTRAR'S SIGNATURE Charles E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13440

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES E. SMITH		M		45		1900		BALTIMORE		BALTIMORE		BALTIMORE		MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
Carpenter		Heart Disease		Natural		1945		BALTIMORE		BALTIMORE		BALTIMORE		MD	
EDUCATION		SCHOOLING		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE	
High School		8		Catholic		White		Caucasian		5' 10"		175		98.6	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY	
Married		Married		Married		Married		Married		1920		BALTIMORE		BALTIMORE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF JURY	
J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith		J. E. Smith	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

13450

13411

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 93 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 24 3V01-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1006 South Kenwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle ----- Last ANUSZEWSKI		4. DATE OF DEATH Month December Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/87
9. AGE (In years lost birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY City	11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Andrew Anuszewski	
14. MOTHER'S MAIDEN NAME Antionette Vinskarski		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clinical Rec. VAH, Baltimore 18, Md. FT. HOWARD DIV.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF THE LEFT LUNG WITH METASTASIS TO REGIONAL LYMPH NODES AND LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA, LEFT (c) PULMONARY EDEMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 162X XXXXXX			INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 1 WEEK 2 DAYS
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from September 14, 1960 to December 16, 1960 , that (2) (we) lost the deceased alive on Dec. 16, 1960 , and that death occurred at 9:35 M, from the causes and on the date stated above.	
22a. SIGNATURE Charles E. Rowan		22b. DATE SIGNED 12-17-60	
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-20-60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town, or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md.		25a. REC'D BY REGISTRAR DEC 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. K...			

CERTIFICATE OF DEATH

13120

<p>1. Name of deceased: [illegible]</p>	
<p>2. Sex: [illegible]</p>	
<p>3. Age: [illegible]</p>	
<p>4. Date of death: [illegible]</p>	
<p>5. Place of death: [illegible]</p>	
<p>6. Cause of death: [illegible]</p>	
<p>7. Signature of physician: [illegible]</p>	
<p>8. Signature of registrar: [illegible]</p>	
<p>9. Date of registration: [illegible]</p>	
<p>10. Place of registration: [illegible]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13440

CERTIFICATE OF DEATH

Reg. Dist. No.

13412

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne				c. LENGTH OF STAY IN 1b 51			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lansdowne Shopping Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle McLain Last Arnett				4. DATE OF DEATH Month December Day 8 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30, 1900	
9. AGE (In years lost birthday) yrs. 60		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Arnett				14. MOTHER'S MAIDEN NAME Emma			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. W.W.I 218-10-8739			
17. INFORMANT Albert Pittinger, 2806 Vermont Avenue				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 12/7/60 , 19 59 , to Dec 8 , 19 60 , that I last saw the deceased alive on 12/7/60 , 19 60 , and that death occurred at 10 A. M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED 203 W Maple Rd 12/9/60							
ACTUAL SIGNATURE Chas. L. Ball Jr. M.D. Lantheim, Md.							
PHYSICIAN'S NAME (Type) Chas. L. Ball, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 12-13-60							
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery							
22d. LOCATION (City, town, or county) (State) Baltimore							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Cook, Inc., 1217 St. Paul Street							
24a. REC'D BY REGISTRAR DATE DEC 13 '60							
24b. REGISTRAR'S SIGNATURE Arthur L. Harris							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

RECEIVED

1840

1840

1840

1840

1840

1840

1840

1840

1840

1840

1840

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and to any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13451

CERTIFICATE OF DEATH

13413

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b yrs.????			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Ellen Middle Ashton Last				4. DATE OF DEATH Month 12-29-60 Day 19 Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-1869	
9. AGE (In years lost birthday) 91 yrs.		10. UNDER 1 YEAR Months 9 Days 1 Hours 1 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Curry				14. MOTHER'S MAIDEN NAME Ellen Riley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Katherine Patterson Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX & LUNG (H.) DUE TO (b) STOMACH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 37 yrs.				INTERVAL BETWEEN ONSET AND DEATH 37 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Dis. (20 yrs)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) FORK, M.D.				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 7, 1964 to Dec 29, 1960 , that (I) (we) last saw the deceased alive on Dec 28, 1960 , and that death occurred 10:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Clifford F. Hudson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON				22d. ADDRESS FORK, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-31-60		23c. NAME OF CEMETERY OR CREMATORY Providence Methodist		23d. LOCATION (City, town, or county) (State) Upper Cross Rd., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 3 '61	
						25b. REGISTRAR'S SIGNATURE Clifford F. Hudson	

1626

1234567891011121314151617181920212223242526272829303132333435363738394041424344454647484950515253545556575859606162636465666768697071727374757677787980818283848586878889909192939495969798991001011021031041051061071081091101111121131141151161171181191201211221231241251261271281291301311321331341351361371381391401411421431441451461471481491501511521531541551561571581591601611621631641651661671681691701711721731741751761771781791801811821831841851861871881891901911921931941951961971981992002012022032042052062072082092102112122132142152162172182192202212222232242252262272282292302312322332342352362372382392402412422432442452462472482492502512522532542552562572582592602612622632642652662672682692702712722732742752762772782792802812822832842852862872882892902912922932942952962972982993003013023033043053063073083093103113123133143153163173183193203213223233243253263273283293303313323333343353363373383393403413423433443453463473483493503513523533543553563573583593603613623633643653663673683693703713723733743753763773783793803813823833843853863873883893903913923933943953963973983994004014024034044054064074084094104114124134144154164174184194204214224234244254264274284294304314324334344354364374384394404414424434444454464474484494504514524534544554564574584594604614624634644654664674684694704714724734744754764774784794804814824834844854864874884894904914924934944954964974984995005015025035045055065075085095105115125135145155165175185195205215225235245255265275285295305315325335345355365375385395405415425435445455465475485495505515525535545555565575585595605615625635645655665675685695705715725735745755765775785795805815825835845855865875885895905915925935945955965975985996006016026036046056066076086096106116126136146156166176186196206216226236246256266276286296306316326336346356366376386396406416426436446456466476486496506516526536546556566576586596606616626636646656666676686696706716726736746756766776786796806816826836846856866876886896906916926936946956966976986997007017027037047057067077087097107117127137147157167177187197207217227237247257267277287297307317327337347357367377387397407417427437447457467477487497507517527537547557567577587597607617627637647657667677687697707717727737747757767777787797807817827837847857867877887897907917927937947957967977987998008018028038048058068078088098108118128138148158168178188198208218228238248258268278288298308318328338348358368378388398408418428438448458468478488498508518528538548558568578588598608618628638648658668678688698708718728738748758768778788798808818828838848858868878888898908918928938948958968978988999009019029039049059069079089099109119129139149159169179189199209219229239249259269279289299309319329339349359369379389399409419429439449459469479489499509519529539549559569579589599609619629639649659669679689699709719729739749759769779789799809819829839849859869879889899909919929939949959969979989991000100110021003100410051006100710081009101010111012101310141015101610171018101910201021102210231024102510261027102810291030103110321033103410351036103710381039104010411042104310441045104610471048104910501051105210531054105510561057105810591060106110621063106410651066106710681069107010711072107310741075107610771078107910801081108210831084108510861087108810891090109110921093109410951096109710981099110011011102110311041105110611071108110911101111111211131114111511161117111811191120112111221123112411251126112711281129113011311132113311341135113611371138113911401141114211431144114511461147114811491150115111521153115411551156115711581159116011611162116311641165116611671168116911701171117211731174117511761177117811791180118111821183118411851186118711881189119011911192119311941195119611971198119912001201120212031204120512061207120812091210121112121213121412151216121712181219122012211222122312241225122612271228122912301231123212331234123512361237123812391240124112421243124412451246124712481249125012511252125312541255125612571258125912601261126212631264126512661267126812691270127112721273127412751276127712781279128012811282128312841285128612871288128912901291129212931294129512961297129812991300130

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13452

13414

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 7 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 6110 Baltimore 28 d. STREET ADDRESS 6110 Old Frederick Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) EDWARD L. AUSTIN		4. DATE OF DEATH Month December Day 27 Year 1960		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH MARCH 3, 1924		9. AGE (In years last birthday) 36 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL LOADER 10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA				11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Joe Austin 14. MOTHER'S MAIDEN NAME Lena Spots			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 244-12-7073 17. INFORMANT Glin Rec VAH Balto 18 Md - Ft Howard Division				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE AND CHRONIC PYELONEPHRITIS (b) UREMIA (c) PARTIAL PARALYSIS BOTH ARMS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 2 MONTHS 9 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that H (this hospital) attended the deceased from Dec. 20, 1960 , to Dec. 27, 1960 that H (we) last saw the deceased alive on Dec. 27, 1960 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.											
22a. SIGNATURE C. M. SNYDER M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 12-27-60			22c. PHYSICIAN'S NAME (Type) VAH Baltimore 18 Md-Ft Howard Division		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-30-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter - Baltimore 16, Md.						25a. REC'D BY REGISTRAR JAN 3 '61			25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

: 1484

ACKNOWLEDGMENTS

— () —

1990/1991

2

1992

50

• • •

11/22/2014 10:01

1053-0525(200605)28:5;1-10

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13453

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13415

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 25 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LINTHICUM HEIGHTS d. STREET ADDRESS 1723 NURSERY ROAD 02X-2	
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last AUTRY		4. DATE OF DEATH Month DECEMBER Day 13 Year 19 60	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18, 1891
9. AGE (In years lost birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER AUTRY		14. MOTHER'S MAIDEN NAME EASTER TEW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW-1		16. SOCIAL SECURITY NO. 705-03-9475	
17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO CHRONIC PYELONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOV. 18, 1960 to DEC. 13, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC. 13, 1960 and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles Allen,		22b. DATE SIGNED 12-13-60	
22c. PHYSICIAN'S NAME (Type) CHARLES ALLEN		22d. ADDRESS M.D. VAH BALTO 18 MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-17-60	
23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) BALTIMORE COUNTY MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. WILSON - BALTIMORE 31, MARYLAND		25a. REC'D BY REGISTRAR DATE DEC 22 '60	
25b. REGISTRAR'S SIGNATURE Charles B. Howard			

MAINTAIN

MAINTAIN

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

THE HOUSE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13454

13416

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 52 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				STREET ADDRESS 818 Chapel Gate Lane			
3. NAME OF DECEASED (Type or print) CHARLES B. AYLOR				4. DATE OF DEATH DECEMBER 25 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/20	
9. AGE (In years last birthday) 40 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		11. BIRTHPLACE (County & State, or foreign country) Craigsville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George F. Aylor				14. MOTHER'S MAIDEN NAME Mary B. Aylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) Yes WW II				16. SOCIAL SECURITY NO. 218-26-2838			
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA, GENERALIZED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EDEMA OF THE LUNGS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Nov. 3 1960 to Dec. 25 1960 , that (we) last saw the deceased alive on Dec. 25 1960 , and that death occurred at 8:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Daniel R. Zohl M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/26/60	
22c. PHYSICIAN'S NAME (Type) DANIEL R. ZOHL M.D.				22d. ADDRESS VAH, Balto. Md. Ft. Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors Baltimore, Maryland				25a. REC'D BY REGISTRAR DEC 28 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13416

13416

Baltimore

Baltimore

Baltimore

25 days

1st Howard

1125 Chapel Gate Lane

Veterans Administration Hospital

60

60

RECEIVED

ALICE

CHARLES

XI

10

12/20

White

Male

Christown, Virginia

General Motors

Legation

Harry E. Taylor

George F. Taylor

210-2200 Blvd. N. W., Wash., D. C., 1st Howard Division

1st Howard

RECEIVED

12/20

Dec. 22, 1950

12/20

60

Dec. 22

12/20/50

1st Howard Division

W.D.

12/20/50

Baltimore, Maryland

Baltimore, Maryland

Baltimore

1101 E. Broadway Ave.

Waste Removal Directors Baltimore, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13417

13455

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rear of 25 Allegany Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2327 N. Calvert Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUIS		4. DATE OF DEATH Month December Day 13 Year 19 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/36
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months 24 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Drug store	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Chas. Barger		14. MOTHER'S MAIDEN NAME Naomi Cox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Betty Barger		Address 2327 N. Calvert St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Parked in vehicle with motor running.	
20c. TIME OF INJURY Month, Day, Year 12/13 19 60 Hour a.m. 03		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Towson Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/60	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Rest		22d. LOCATION (City, town, or country) (State) Towson Balt. Co. Md.	
23. FUNERAL DIRECTOR Wm. L. Glatman ADDRESS 1701 N. Calvert St Baltimore, Md.		24a. REC'D BY REGISTRAR DEC 19 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

EXAMINER CERTIFICATE OF DEATH

1917

Jan. 1917

Baltimore

2327 N. Calvert Street

December 13

HANOVER

1917

Colored

Male

Carbon and the following



Entered in vehicle with motor running.

Baltimore

Street

X

X

1917

Charles B. Davis, D.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
13456
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13418

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Garrison		c. LENGTH OF STAY IN 1b Approx 2yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home, Garrison Md.		d. STREET ADDRESS 24 Old Tollgate Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Dulany Last Barker		4. DATE OF DEATH Month December Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/75
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 14 Days 20 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Dulany		14. MOTHER'S MAIDEN NAME Eleanor Simmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lee Richardson		Address Owings Mills, Md. 24 Old Tollgate Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO arterio sclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) arterio sclerosis DUE TO (c) arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH 14 hours 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 14, 1958 to Dec 22, 1960 that (I) was last saw the deceased alive on Dec 22, 1960 , and that death occurred at 1:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Frank F. Williams		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FRANK F. WILLIAMS		22d. ADDRESS Pikesville 8, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 27, 1960	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell, Pikesville 8, Md.		25a. REC'D BY REGISTRAR DEC 30 '60	
25b. REGISTRAR'S SIGNATURE Frank D. Newell			

13418

CERTIFICATE OF DEATH

13418

Deaths

No.

Age

Sex

Color

Marital

Occupation

Education

Place of Birth

Usual Residence

Place of Death

Date of Death

Cause of Death

Medical Attendant

Physician

Funeral Home

Signature

Registrar

County

State

Year

Witnesses

CHIEF CLERK

13418

13418

13418

13418

13418

13418

13418

13418

13418

13418

1

M
050
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13419
13457
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 49 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle M. Last BARROW				4. DATE OF DEATH Month December Day 13 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-15-87	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARINE PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY U.S. COAST GUARD		11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT H. BARROW				14. MOTHER'S MAIDEN NAME JOSIE ADDAWAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 215-03-8534		17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PANCREAS WITH METASTASES TO THE LEFT LUNG, LEFT KIDNEY, RIGHT ADRENAL AND MEDIASTINAL LYMPH NODES Conditions, if any, which gave rise to immediate cause (b) EDEMA OF LUNGS, MARKED cause (a), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4 DAYS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT. 25, 1960 to DEC. 13, 1960 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on DEC. 13, 1960 , and that death occurred at 2:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE 12/15/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD.FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-16-60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town, or county) Baltimore	(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.			25a. REC'D BY REGISTRAR DEC 19 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

DECEASED

DATE

PLACE

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE

12

19-1-17

1917

12

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13458 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridge Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> d. STREET ADDRESS <u>1 Ridge Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Washington Bayer</u> First Middle Last 4. DATE OF DEATH <u>Dec. 14</u> 19 <u>60</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 27, 1880</u> 9. AGE (In years last birthday) <u>50</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm (owner)</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John George Bayer</u> 14. MOTHER'S MAIDEN NAME <u>Magdalena Derr</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>217-36-3808</u> 17. INFORMANT <u>Mrs Cora E. Bayer</u> Address <u>Box 7, Md Ridge Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/17/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Randallstown Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>George Bayer</u> ADDRESS <u>8725 Liberty Road Randallstown, Md</u> 24. REC'D BY REGISTRAR DATE <u>DEC 15 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-59 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13421

13459

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Mt. Wilson, Md.</u>				<u>COCKEYSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 27 ASHLAND Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CLIFTON EUGENE BEACH</u>				<u>12 29 1960</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>6-12-1902</u>	<u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>moving & storage</u>		<u>VIRGINIA</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN BEACH</u>				<u>DORA WORKMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>YES</u> <u>21-25</u>		<u>215-14-9634</u>		<u>Hospital Records, Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 years</u>	
<u>163X</u> IMMEDIATE CAUSE (A) <u>PULMONARY CARCINOMA</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>EMPHYSEMA (PULMONARY)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-11</u>, 19<u>60</u>, to <u>12-29</u>, 19<u>60</u>, that I last saw the deceased alive on <u>12-29</u>, 19<u>60</u>, and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
<u>Wm. Newcomer</u>		<u>Wm. Newcomer, M.D., Superintendent, Mt. Wilson, Md.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-31-60</u>		<u>Ashland Presbyterian</u>		<u>Cockeysville, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 3 '61</u>		<u>Arthur S. Francis</u>		<u>BROCKS FUNERAL SER.</u>		<u>622 YORK ROAD TOWSON, Md.</u>	
DATE							

SHORTCUTS

THIS FORM IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE A MEDICAL JUDGMENT AS TO THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL TRANSMIT IT TO THE STATE DEPARTMENT OF HEALTH. IT IS IMPORTANT THAT THE INFORMATION BE GIVEN BE TRUE AND CORRECT. THE REGISTRAR WILL NOT BE RESPONSIBLE FOR THE CONSEQUENCES OF FALSE INFORMATION.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1961

Form 10-1

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. MARITAL STATUS

7. DATE OF BIRTH

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. PLACE OF BIRTH

12. PLACE OF DEATH

13. DATE OF DEATH

14. TIME OF DEATH

15. PLACE OF DEATH

16. DATE OF DEATH

17. TIME OF DEATH

18. PLACE OF DEATH

19. DATE OF DEATH

20. TIME OF DEATH

21. PLACE OF DEATH

22. DATE OF DEATH

23. TIME OF DEATH

24. PLACE OF DEATH

25. DATE OF DEATH

26. TIME OF DEATH

27. PLACE OF DEATH

28. DATE OF DEATH

29. TIME OF DEATH

30. PLACE OF DEATH

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF DEATH

34. DATE OF DEATH

35. TIME OF DEATH

36. PLACE OF DEATH

37. DATE OF DEATH

38. TIME OF DEATH

39. PLACE OF DEATH

40. DATE OF DEATH

41. TIME OF DEATH

42. PLACE OF DEATH

43. DATE OF DEATH

44. TIME OF DEATH

45. PLACE OF DEATH

46. DATE OF DEATH

47. TIME OF DEATH

48. PLACE OF DEATH

49. DATE OF DEATH

50. TIME OF DEATH

51. PLACE OF DEATH

52. DATE OF DEATH

53. TIME OF DEATH

54. PLACE OF DEATH

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF DEATH

58. DATE OF DEATH

59. TIME OF DEATH

60. PLACE OF DEATH

61. DATE OF DEATH

62. TIME OF DEATH

63. PLACE OF DEATH

64. DATE OF DEATH

65. TIME OF DEATH

66. PLACE OF DEATH

67. DATE OF DEATH

68. TIME OF DEATH

69. PLACE OF DEATH

70. DATE OF DEATH

71. TIME OF DEATH

72. PLACE OF DEATH

73. DATE OF DEATH

74. TIME OF DEATH

75. PLACE OF DEATH

76. DATE OF DEATH

77. TIME OF DEATH

78. PLACE OF DEATH

79. DATE OF DEATH

80. TIME OF DEATH

81. PLACE OF DEATH

82. DATE OF DEATH

83. TIME OF DEATH

84. PLACE OF DEATH

85. DATE OF DEATH

86. TIME OF DEATH

87. PLACE OF DEATH

88. DATE OF DEATH

89. TIME OF DEATH

90. PLACE OF DEATH

91. DATE OF DEATH

92. TIME OF DEATH

93. PLACE OF DEATH

94. DATE OF DEATH

95. TIME OF DEATH

96. PLACE OF DEATH

97. DATE OF DEATH

98. TIME OF DEATH

99. PLACE OF DEATH

100. DATE OF DEATH

99. TIME OF DEATH

100. PLACE OF DEATH

101. DATE OF DEATH

100. TIME OF DEATH

101. PLACE OF DEATH

102. DATE OF DEATH

101. TIME OF DEATH

102. PLACE OF DEATH

103. DATE OF DEATH

102. TIME OF DEATH

103. PLACE OF DEATH

104. DATE OF DEATH

103. TIME OF DEATH

104. PLACE OF DEATH

105. DATE OF DEATH

104. TIME OF DEATH

105. PLACE OF DEATH

106. DATE OF DEATH

105. TIME OF DEATH

106. PLACE OF DEATH

107. DATE OF DEATH

106. TIME OF DEATH

107. PLACE OF DEATH

108. DATE OF DEATH

107. TIME OF DEATH

108. PLACE OF DEATH

109. DATE OF DEATH

108. TIME OF DEATH

109. PLACE OF DEATH

110. DATE OF DEATH

109. TIME OF DEATH

110. PLACE OF DEATH

111. DATE OF DEATH

110. TIME OF DEATH

111. PLACE OF DEATH

112. DATE OF DEATH

111. TIME OF DEATH

112. PLACE OF DEATH

113. DATE OF DEATH

112. TIME OF DEATH

113. PLACE OF DEATH

114. DATE OF DEATH

113. TIME OF DEATH

114. PLACE OF DEATH

115. DATE OF DEATH

114. TIME OF DEATH

115. PLACE OF DEATH

116. DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13460

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13422

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 3 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAY Last BENSON		4. DATE OF DEATH Month DEC Day 14 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME GEORGE RIDER		14. MOTHER'S MAIDEN NAME SARAH JANE SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-24-5384 A	
17. INFORMANT Frank L. Smith Jr. Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardiovascular DUE TO (c) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH few hours 2 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-11 19 57 to 12-12 19 60 ; that (I) (we) last saw the deceased alive on 12-12 19 60 , and that death occurred at 6:30 A. from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 12/14/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-16-60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Inc., 1217 St. Paul Street, Zone 2		25a. REGISTERED BY REGISTRAR DEC 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

07381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex #21</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex #21</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1111 "C" Eastern Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sandra</u> <u>Evelene</u> <u>Bentley</u>				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1951</u>	
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Paris Bentley</u>				14. MOTHER'S MAIDEN NAME <u>Marcella Adkin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Paris Bentley</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - left lung</u> DUE TO (b) <u>Measles</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Palsy</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/1/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Call & Son Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Pikeville, Kentucky</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Brudzinski</u>				ADDRESS <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13462

13424

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 2 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALICE M BENTZEL		4. DATE OF DEATH Month Day Year DEC 18 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 8, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U-S	
13. FATHER'S NAME HENRY J BENTZEL		14. MOTHER'S MAIDEN NAME MARY SWITZER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-14-4581	
17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 DUE TO Arterio Sclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Disease (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-12 1960 to 12-16 1960 , that (I) (we) last saw the deceased alive on 12-16 1960 , and that death occurred at 7:45 P M, from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 12/18/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, (Specify) BURIAL		23b. DATE THEREOF 12-20-60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE DEC 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

13463

CERTIFICATE OF DEATH

13425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2mth13dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Beresford</u> Last <u>Beresford</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1881</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown Allen Beresford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Oct. 6, 1960</u> to <u>Dec. 19, 1960</u> , that I last saw the deceased alive on <u>Dec. 19, 1960</u> , and that death occurred at <u>1:00p M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		DATE SIGNED <u>12-19-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-21-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 22 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
X
M
X
I
0
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13464						13426					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Baltimore</i> MARYLAND						a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8006 Highpoint Road</i>						d. STREET ADDRESS <i>8006 Highpoint Road</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Mr. Martin Bildstein</i>						4. DATE OF DEATH <i>December 14 19 60</i>					
5. SEX <i>male</i>						6. COLOR OR RACE <i>white</i>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <i>July 28, 1892</i>					
9. AGE (In years last birthday) <i>68</i> yrs.						10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>Easton, Maryland</i>					
11. BIRTHPLACE (County & State, or foreign country) <i>USA</i>						12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Joseph Bildstein</i>						14. MOTHER'S MAIDEN NAME <i>Mary Martin</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>213-01-8332</i>						16. SOCIAL SECURITY NO. <i>213-01-8332</i>					
17. INFORMANT <i>Mrs. Nannie May Bildstein,</i>						Address <i>same</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH <i>9 months</i>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>190.9</i> DUE TO <i>Melanoma with metastases</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO											
(c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>9-28-60</i> , 19 <i>60</i> , to <i>12-13</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>10-7</i> , 19 <i>60</i> , and that death occurred at <i>10</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i>						22b. DATE SIGNED <i>12-15-60</i>					
22c. PHYSICIAN'S NAME (Type) <i>DR JOS. SKLOVEN</i>						22d. ADDRESS <i>7122 Harford Rd</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>12/17/60</i>					
23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>						23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>						25a. REC'D BY REGISTRAR <i>DEC 16 '60</i>					
ADDRESS <i>5305 Harford Road #14</i>						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

03481

1951

81.51

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13465

CERTIFICATE OF DEATH

13427

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 37 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HORACE Middle W Last BIVINS				4. DATE OF DEATH Month December Day 4 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1866	
9. AGE (In years lost birthday) 94 yrs.		IF UNDER 1 YEAR Months 94 Days 94 Hours 94 Min.		IF UNDER 24 HRS. Months 94 Days 94 Hours 94 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier				10b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
11. BIRTHPLACE (State or foreign country) Accomack Co., Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Severn Bivins				14. MOTHER'S MAIDEN NAME Elizabeth Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-1 & SAW			
17. INFORMANT Clinical Records				Address VAH Baltimore 18, Maryland-FORT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ENTERORRHAGIA DUE TO (c) LEIOMYOMA OF THE STOMACH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 2 MONTHS UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 28 19 60 to Dec. 4 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 4 19 60 , and that death occurred at 4:50 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE SIGNED 12/5/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, Baltimore 18, Maryland VAH, Fort Howard, Maryland Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/8/60			
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery				23d. LOCATION (City, town, or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR 1808 N. Monroe St. Baltimore 17, Maryland DATE DEC 12 '60			
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1943

CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13466 **CERTIFICATE OF DEATH**

13428

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.			c. LENGTH OF STAY IN 1b 31 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 626 Westh Dennison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LUBY Middle ---- Last BLOUNT, JR.				4. DATE OF DEATH Month December Day 15 Year 1960				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 21, 1921		
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 3 Days 0 Hours 1 Min. 4		IF UNDER 24 HRS. Hours 1 Min. 4				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver			10b. KIND OF BUSINESS OR INDUSTRY Truck		11. BIRTHPLACE (State or foreign country) Greene Co., N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Luby Blount				14. MOTHER'S MAIDEN NAME Mittie Malone				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 234-26-3462		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. Fort Howard Div.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATIC VALVULAR DISEASE OF THE HEART 416X XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC PERICARDITIS DUE TO (c) MARKED HYPERTROPHY AND DILATATION OF HEART							INTERVAL BETWEEN ONSET AND DEATH 17 YEARS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 14, 1960 to December 15, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 15, 1960 , and that death occurred at 10:45 A. M., from the causes and on the date stated above.								
22a. SIGNATURE <i>Armen Bogosian</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/16/60		
22c. PHYSICIAN'S NAME (Type) Armen Bogosian				22d. ADDRESS VAH, BALTIMORE, MD., FORT HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12-17-1960		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) North Carolina		
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St.				25a. REC'D BY REGISTRAR DEC 19 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Ship To: Joe R. Joyner & Son, Farmville, N.C., Baltimore 17, Md.

13488

CERTIFICATE OF DEATH

13488



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13467

CERTIFICATE OF DEATH

13429

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND f. COUNTY BALTIMORE g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE h. STREET ADDRESS 515 NORTH STRICKER STREET i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLIE W. BOOKER				4. DATE OF DEATH Month December Day 26 Year 19 60			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 9, 1913 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR				10b. KIND OF BUSINESS OR INDUSTRY APARTMENT BUILDING		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
13. FATHER'S NAME LOUIS BOOKER				14. MOTHER'S MAIDEN NAME GEORGIA GUNN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give word dates of service) WW-11				16. SOCIAL SECURITY NO. 239-09-5926			
17. INFORMANT CLIN REC VAH BALTO 18 MD - FT HOWARD DIVISION				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CELLULITIS OF THE GENITAL ORGANS AND LOWER ABDOMEN						2 WEEKS	
Conditions, if any, which gave rise to immediate cause (b) BILATERAL FIBROCASEOUS TUBERCULOSIS, LUNGS						UNKNOWN	
(c) BRONCHOPNEUMONIA LOWER RIGHT LOBE						UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
EDEMA OF THE LUNGS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 22, 1960 , to Dec. 26, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 26, 1960 , and that death occurred at 2:40 a.m. from the causes and on the date stated above.							
22a. SIGNATURE C. M. SNYDER, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-27-60	
22c. PHYSICIAN'S ADDRESS VAH BALTO 18 MD - FT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/30/1960		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Katie R. Williams				25a. REC'D BY REGISTRAR DEC 29 '60		25b. REGISTRAR'S SIGNATURE	
322 N SCHROEDER ST BALTIMORE 23 Md							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13487

13487

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MAINTENANCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13468

CERTIFICATE OF DEATH

13430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b 20 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5425 W. North Ave.,		e. STREET ADDRESS 5425 W. North Ave.,	
3. NAME OF DECEASED (Type or print) John William Bossert		4. DATE OF DEATH Month Dec. Day 23, Year 19 60.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Bossert		14. MOTHER'S MAIDEN NAME Anna Hechmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-16-7930	
17. INFORMANT Mrs. Clare R. Bossert		Address 5425 W. North Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema & generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10/58 , 19____, to 12/22/60 , 19____, that I last saw the deceased alive on 12/22/60 , 19____, and that death occurred at 2 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6410 Woodson Hill Rd Baltimore 7 Md ACTUAL SIGNATURE Milton Schlenoff M.D. 12/23/60 PHYSICIAN'S NAME (Type) Milton Schlenoff			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-1960	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W. North Ave.	
24a. REC'D BY REGISTRAR DEC 27 1960		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

100

1000

(continued)

Model	Results	χ^2	df	p
Model 1		10.00	1	0.002
Model 2		10.00	1	0.002
Model 3		10.00	1	0.002
Model 4		10.00	1	0.002
Model 5		10.00	1	0.002
Model 6		10.00	1	0.002
Model 7		10.00	1	0.002
Model 8		10.00	1	0.002
Model 9		10.00	1	0.002
Model 10		10.00	1	0.002
Model 11		10.00	1	0.002
Model 12		10.00	1	0.002
Model 13		10.00	1	0.002
Model 14		10.00	1	0.002
Model 15		10.00	1	0.002
Model 16		10.00	1	0.002
Model 17		10.00	1	0.002
Model 18		10.00	1	0.002
Model 19		10.00	1	0.002
Model 20		10.00	1	0.002
Model 21		10.00	1	0.002
Model 22		10.00	1	0.002
Model 23		10.00	1	0.002
Model 24		10.00	1	0.002
Model 25		10.00	1	0.002
Model 26		10.00	1	0.002
Model 27		10.00	1	0.002
Model 28		10.00	1	0.002
Model 29		10.00	1	0.002
Model 30		10.00	1	0.002
Model 31		10.00	1	0.002
Model 32		10.00	1	0.002
Model 33		10.00	1	0.002
Model 34		10.00	1	0.002
Model 35		10.00	1	0.002
Model 36		10.00	1	0.002
Model 37		10.00	1	0.002
Model 38		10.00	1	0.002
Model 39		10.00	1	0.002
Model 40		10.00	1	0.002
Model 41		10.00	1	0.002
Model 42		10.00	1	0.002
Model 43		10.00	1	0.002
Model 44		10.00	1	0.002
Model 45		10.00	1	0.002
Model 46		10.00	1	0.002
Model 47		10.00	1	0.002
Model 48		10.00	1	0.002
Model 49		10.00	1	0.002
Model 50		10.00	1	0.002
Model 51		10.00	1	0.002
Model 52		10.00	1	0.002
Model 53		10.00	1	0.002
Model 54		10.00	1	0.002
Model 55		10.00	1	0.002
Model 56		10.00	1	0.002
Model 57		10.00	1	0.002
Model 58		10.00	1	0.002
Model 59		10.00	1	0.002
Model 60		10.00	1	0.002
Model 61		10.00	1	0.002
Model 62		10.00	1	0.002
Model 63		10.00	1	0.002
Model 64		10.00	1	0.002
Model 65		10.00	1	0.002
Model 66		10.00	1	0.002
Model 67		10.00	1	0.002
Model 68		10.00	1	0.002
Model 69		10.00	1	0.002
Model 70		10.00	1	0.002
Model 71		10.00	1	0.002
Model 72		10.00	1	0.002
Model 73		10.00	1	0.002
Model 74		10.00	1	0.002
Model 75		10.00	1	0.002
Model 76		10.00	1	0.002
Model 77		10.00	1	0.002
Model 78		10.00	1	0.002
Model 79		10.00	1	0.002
Model 80				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to a burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13431

13469

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey 21 Md</u>		c. LENGTH OF STAY IN 1b <u>30</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1411 Goodwood Ave</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey 21 Md. 51</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Cyle</u> Last <u>Boston</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 '77</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shaver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>on Gen.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dustin Boston</u>		14. MOTHER'S MAIDEN NAME <u>Jimmie P</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>T</u>	
17. INFORMANT <u>Eva Boston</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic H.P.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stevens</u>		22d. LOCATION (City, town, or county) (State) <u>Essey Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Choy O. Wilson</u>		ADDRESS <u>1100 Brantley Ave</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

DATE SIGNED

12-19-60

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13481

PART I. DEATH 1. DATE OF DEATH: <u>1918</u> 2. TIME OF DEATH: <u>11:00 A.M.</u> 3. PLACE OF DEATH: <u>Home</u> 4. NAME OF DECEASED: <u>John Doe</u> 5. AGE: <u>45</u> YEARS 6. SEX: <u>Male</u> 7. OCCUPATION: <u>Farmer</u> 8. MARITAL STATUS: <u>Married</u> 9. PLACE OF BIRTH: <u>Illinois</u> 10. COLOR: <u>White</u> 11. RELIGION: <u>Methodist</u> 12. EDUCATION: <u>High School</u> 13. PREVIOUS ILLNESS: <u>None</u> 14. CAUSE OF DEATH: <u>Heart Disease</u> 15. MANNER OF DEATH: <u>Natural</u> 16. SIGNATURE OF EXAMINER: <u>[Signature]</u> 17. DATE OF EXAMINATION: <u>1918</u> 18. PLACE OF EXAMINATION: <u>Home</u> 19. NAME OF PHYSICIAN: <u>Dr. Smith</u> 20. ADDRESS OF PHYSICIAN: <u>123 Main St.</u> 21. CITY: <u>Springfield</u> 22. COUNTY: <u>Clark</u> 23. STATE: <u>Illinois</u> 24. ZIP CODE: <u>62761</u> 25. TELEPHONE: <u>1234</u> 26. HOURS OF SERVICE: <u>24 Hours</u> 27. NAME OF HOSPITAL: <u>None</u> 28. ADDRESS OF HOSPITAL: <u>None</u> 29. CITY: <u>None</u> 30. COUNTY: <u>None</u> 31. STATE: <u>None</u> 32. ZIP CODE: <u>None</u> 33. TELEPHONE: <u>None</u> 34. HOURS OF SERVICE: <u>None</u> 35. NAME OF NURSE: <u>None</u> 36. ADDRESS OF NURSE: <u>None</u> 37. CITY: <u>None</u> 38. COUNTY: <u>None</u> 39. STATE: <u>None</u> 40. ZIP CODE: <u>None</u> 41. TELEPHONE: <u>None</u> 42. HOURS OF SERVICE: <u>None</u> 43. NAME OF DOCTOR: <u>None</u> 44. ADDRESS OF DOCTOR: <u>None</u> 45. CITY: <u>None</u> 46. COUNTY: <u>None</u> 47. STATE: <u>None</u> 48. ZIP CODE: <u>None</u> 49. TELEPHONE: <u>None</u> 50. HOURS OF SERVICE: <u>None</u> 51. NAME OF PHYSICIAN: <u>None</u> 52. ADDRESS OF PHYSICIAN: <u>None</u> 53. CITY: <u>None</u> 54. COUNTY: <u>None</u> 55. STATE: <u>None</u> 56. ZIP CODE: <u>None</u> 57. TELEPHONE: <u>None</u> 58. HOURS OF SERVICE: <u>None</u> 59. NAME OF NURSE: <u>None</u> 60. ADDRESS OF NURSE: <u>None</u> 61. CITY: <u>None</u> 62. COUNTY: <u>None</u> 63. STATE: <u>None</u> 64. ZIP CODE: <u>None</u> 65. TELEPHONE: <u>None</u> 66. HOURS OF SERVICE: <u>None</u> 67. NAME OF DOCTOR: <u>None</u> 68. ADDRESS OF DOCTOR: <u>None</u> 69. CITY: <u>None</u> 70. COUNTY: <u>None</u> 71. STATE: <u>None</u> 72. ZIP CODE: <u>None</u> 73. TELEPHONE: <u>None</u> 74. HOURS OF SERVICE: <u>None</u> 75. NAME OF PHYSICIAN: <u>None</u> 76. ADDRESS OF PHYSICIAN: <u>None</u> 77. CITY: <u>None</u> 78. COUNTY: <u>None</u> 79. STATE: <u>None</u> 80. ZIP CODE: <u>None</u> 81. TELEPHONE: <u>None</u> 82. HOURS OF SERVICE: <u>None</u> 83. NAME OF NURSE: <u>None</u> 84. ADDRESS OF NURSE: <u>None</u> 85. CITY: <u>None</u> 86. COUNTY: <u>None</u> 87. STATE: <u>None</u> 88. ZIP CODE: <u>None</u> 89. TELEPHONE: <u>None</u> 90. HOURS OF SERVICE: <u>None</u> 91. NAME OF DOCTOR: <u>None</u> 92. ADDRESS OF DOCTOR: <u>None</u> 93. CITY: <u>None</u> 94. COUNTY: <u>None</u> 95. STATE: <u>None</u> 96. ZIP CODE: <u>None</u> 97. TELEPHONE: <u>None</u> 98. HOURS OF SERVICE: <u>None</u> 99. NAME OF PHYSICIAN: <u>None</u> 100. ADDRESS OF PHYSICIAN: <u>None</u> 101. CITY: <u>None</u> 102. COUNTY: <u>None</u> 103. STATE: <u>None</u> 104. ZIP CODE: <u>None</u> 105. TELEPHONE: <u>None</u> 106. HOURS OF SERVICE: <u>None</u> 107. NAME OF NURSE: <u>None</u> 108. ADDRESS OF NURSE: <u>None</u> 109. CITY: <u>None</u> 110. COUNTY: <u>None</u> 111. STATE: <u>None</u> 112. ZIP CODE: <u>None</u> 113. TELEPHONE: <u>None</u> 114. HOURS OF SERVICE: <u>None</u> 115. NAME OF DOCTOR: <u>None</u> 116. ADDRESS OF DOCTOR: <u>None</u> 117. CITY: <u>None</u> 118. COUNTY: <u>None</u> 119. STATE: <u>None</u> 120. ZIP CODE: <u>None</u> 121. TELEPHONE: <u>None</u> 122. HOURS OF SERVICE: <u>None</u> 123. NAME OF PHYSICIAN: <u>None</u> 124. ADDRESS OF PHYSICIAN: <u>None</u> 125. CITY: <u>None</u> 126. COUNTY: <u>None</u> 127. STATE: <u>None</u> 128. ZIP CODE: <u>None</u> 129. TELEPHONE: <u>None</u> 130. HOURS OF SERVICE: <u>None</u> 131. NAME OF NURSE: <u>None</u> 132. ADDRESS OF NURSE: <u>None</u> 133. CITY: <u>None</u> 134. COUNTY: <u>None</u> 135. STATE: <u>None</u> 136. ZIP CODE: <u>None</u> 137. TELEPHONE: <u>None</u> 138. HOURS OF SERVICE: <u>None</u> 139. NAME OF DOCTOR: <u>None</u> 140. ADDRESS OF DOCTOR: <u>None</u> 141. CITY: <u>None</u> 142. COUNTY: <u>None</u> 143. STATE: <u>None</u> 144. ZIP CODE: <u>None</u> 145. TELEPHONE: <u>None</u> 146. HOURS OF SERVICE: <u>None</u> 147. NAME OF PHYSICIAN: <u>None</u> 148. ADDRESS OF PHYSICIAN: <u>None</u> 149. CITY: <u>None</u> 150. COUNTY: <u>None</u> 151. STATE: <u>None</u> 152. ZIP CODE: <u>None</u> 153. TELEPHONE: <u>None</u> 154. HOURS OF SERVICE: <u>None</u> 155. NAME OF NURSE: <u>None</u> 156. ADDRESS OF NURSE: <u>None</u> 157. CITY: <u>None</u> 158. COUNTY: <u>None</u> 159. STATE: <u>None</u> 160. ZIP CODE: <u>None</u> 161. TELEPHONE: <u>None</u> 162. HOURS OF SERVICE: <u>None</u> 163. NAME OF DOCTOR: <u>None</u> 164. ADDRESS OF DOCTOR: <u>None</u> 165. CITY: <u>None</u> 166. COUNTY: <u>None</u> 167. STATE: <u>None</u> 168. ZIP CODE: <u>None</u> 169. TELEPHONE: <u>None</u> 170. HOURS OF SERVICE: <u>None</u> 171. NAME OF PHYSICIAN: <u>None</u> 172. ADDRESS OF PHYSICIAN: <u>None</u> 173. CITY: <u>None</u> 174. COUNTY: <u>None</u> 175. STATE: <u>None</u> 176. ZIP CODE: <u>None</u> 177. TELEPHONE: <u>None</u> 178. HOURS OF SERVICE: <u>None</u> 179. NAME OF NURSE: <u>None</u> 180. ADDRESS OF NURSE: <u>None</u> 181. CITY: <u>None</u> 182. COUNTY: <u>None</u> 183. STATE: <u>None</u> 184. ZIP CODE: <u>None</u> 185. TELEPHONE: <u>None</u> 186. HOURS OF SERVICE: <u>None</u> 187. NAME OF DOCTOR: <u>None</u> 188. ADDRESS OF DOCTOR: <u>None</u> 189. CITY: <u>None</u> 190. COUNTY: <u>None</u> 191. STATE: <u>None</u> 192. ZIP CODE: <u>None</u> 193. TELEPHONE: <u>None</u> 194. HOURS OF SERVICE: <u>None</u> 195. NAME OF PHYSICIAN: <u>None</u> 196. ADDRESS OF PHYSICIAN: <u>None</u> 197. CITY: <u>None</u> 198. COUNTY: <u>None</u> 199. STATE: <u>None</u> 200. ZIP CODE: <u>None</u> 201. TELEPHONE: <u>None</u> 202. HOURS OF SERVICE: <u>None</u> 203. NAME OF NURSE: <u>None</u> 204. ADDRESS OF NURSE: <u>None</u> 205. CITY: <u>None</u> 206. COUNTY: <u>None</u> 207. STATE: <u>None</u> 208. ZIP CODE: <u>None</u> 209. TELEPHONE: <u>None</u> 210. HOURS OF SERVICE: <u>None</u> 211. NAME OF DOCTOR: <u>None</u> 212. ADDRESS OF DOCTOR: <u>None</u> 213. CITY: <u>None</u> 214. COUNTY: <u>None</u> 215. STATE: <u>None</u> 216. ZIP CODE: <u>None</u> 217. TELEPHONE: <u>None</u> 218. HOURS OF SERVICE: <u>None</u> 219. NAME OF PHYSICIAN: <u>None</u> 220. ADDRESS OF PHYSICIAN: <u>None</u> 221. CITY: <u>None</u> 222. COUNTY: <u>None</u> 223. STATE: <u>None</u> 224. ZIP CODE: <u>None</u> 225. TELEPHONE: <u>None</u> 226. HOURS OF SERVICE: <u>None</u> 227. NAME OF NURSE: <u>None</u> 228. ADDRESS OF NURSE: <u>None</u> 229. CITY: <u>None</u> 230. COUNTY: <u>None</u> 231. STATE: <u>None</u> 232. ZIP CODE: <u>None</u> 233. TELEPHONE: <u>None</u> 234. HOURS OF SERVICE: <u>None</u> 235. NAME OF DOCTOR: <u>None</u> 236. ADDRESS OF DOCTOR: <u>None</u> 237. CITY: <u>None</u> 238. COUNTY: <u>None</u> 239. STATE: <u>None</u> 240. ZIP CODE: <u>None</u> 241. TELEPHONE: <u>None</u> 242. HOURS OF SERVICE: <u>None</u> 243. NAME OF PHYSICIAN: <u>None</u> 244. ADDRESS OF PHYSICIAN: <u>None</u> 245. CITY: <u>None</u> 246. COUNTY: <u>None</u> 247. STATE: <u>None</u> 248. ZIP CODE: <u>None</u> 249. TELEPHONE: <u>None</u> 250. HOURS OF SERVICE: <u>None</u> 251. NAME OF NURSE: <u>None</u> 252. ADDRESS OF NURSE: <u>None</u> 253. CITY: <u>None</u> 254. COUNTY: <u>None</u> 255. STATE: <u>None</u> 256. ZIP CODE: <u>None</u> 257. TELEPHONE: <u>None</u> 258. HOURS OF SERVICE: <u>None</u> 259. NAME OF DOCTOR: <u>None</u> 260. ADDRESS OF DOCTOR: <u>None</u> 261. CITY: <u>None</u> 262. COUNTY: <u>None</u> 263. STATE: <u>None</u> 264. ZIP CODE: <u>None</u> 265. TELEPHONE: <u>None</u> 266. HOURS OF SERVICE: <u>None</u> 267. NAME OF PHYSICIAN: <u>None</u> 268. ADDRESS OF PHYSICIAN: <u>None</u> 269. CITY: <u>None</u> 270. COUNTY: <u>None</u> 271. STATE: <u>None</u> 272. ZIP CODE: <u>None</u> 273. TELEPHONE: <u>None</u> 274. HOURS OF SERVICE: <u>None</u> 275. NAME OF NURSE: <u>None</u> 276. ADDRESS OF NURSE: <u>None</u> 277. CITY: <u>None</u> 278. COUNTY: <u>None</u> 279. STATE: <u>None</u> 280. ZIP CODE: <u>None</u> 281. TELEPHONE: <u>None</u> 282. HOURS OF SERVICE: <u>None</u> 283. NAME OF DOCTOR: <u>None</u> 284. ADDRESS OF DOCTOR: <u>None</u> 285. CITY: <u>None</u> 286. COUNTY: <u>None</u> 287. STATE: <u>None</u> 288. ZIP CODE: <u>None</u> 289. TELEPHONE: <u>None</u> 290. HOURS OF SERVICE: <u>None</u> 291. NAME OF PHYSICIAN: <u>None</u> 292. ADDRESS OF PHYSICIAN: <u>None</u> 293. CITY: <u>None</u> 294. COUNTY: <u>None</u> 295. STATE: <u>None</u> 296. ZIP CODE: <u>None</u> 297. TELEPHONE: <u>None</u> 298. HOURS OF SERVICE: <u>None</u> 299. NAME OF NURSE: <u>None</u> 300. ADDRESS OF NURSE: <u>None</u> 301. CITY: <u>None</u> 302. COUNTY: <u>None</u> 303. STATE: <u>None</u> 304. ZIP CODE: <u>None</u> 305. TELEPHONE: <u>None</u> 306. HOURS OF SERVICE: <u>None</u> 307. NAME OF DOCTOR: <u>None</u> 308. ADDRESS OF DOCTOR: <u>None</u> 309. CITY: <u>None</u> 310. COUNTY: <u>None</u> 311. STATE: <u>None</u> 312. ZIP CODE: <u>None</u> 313. TELEPHONE: <u>None</u> 314. HOURS OF SERVICE: <u>None</u> 315. NAME OF PHYSICIAN: <u>None</u> 316. ADDRESS OF PHYSICIAN: <u>None</u> 317. CITY: <u>None</u> 318. COUNTY: <u>None</u> 319. STATE: <u>None</u> 320. ZIP CODE: <u>None</u> 321. TELEPHONE: <u>None</u> 322. HOURS OF SERVICE: <u>None</u> 323. NAME OF NURSE: <u>None</u> 324. ADDRESS OF NURSE: <u>None</u> 325. CITY: <u>None</u> 326. COUNTY: <u>None</u> 327. STATE: <u>None</u> 328. ZIP CODE: <u>None</u> 329. TELEPHONE: <u>None</u> 330. HOURS OF SERVICE: <u>None</u> 331. NAME OF DOCTOR: <u>None</u> 332. ADDRESS OF DOCTOR: <u>None</u> 333. CITY: <u>None</u> 334. COUNTY: <u>None</u> 335. STATE: <u>None</u> 336. ZIP CODE: <u>None</u> 337. TELEPHONE: <u>None</u> 338. HOURS OF SERVICE: <u>None</u> 339. NAME OF PHYSICIAN: <u>None</u> 340. ADDRESS OF PHYSICIAN: <u>None</u> 341. CITY: <u>None</u> 342. COUNTY: <u>None</u> 343. STATE: <u>None</u> 344. ZIP CODE: <u>None</u> 345. TELEPHONE: <u>None</u> 346. HOURS OF SERVICE: <u>None</u> 347. NAME OF NURSE: <u>None</u> 348. ADDRESS OF NURSE: <u>None</u> 349. CITY: <u>None</u> 350. COUNTY: <u>None</u> 351. STATE: <u>None</u> 352. ZIP CODE: <u>None</u> 353. TELEPHONE: <u>None</u> 354. HOURS OF SERVICE: <u>None</u> 355. NAME OF DOCTOR: <u>None</u> 356. ADDRESS OF DOCTOR: <u>None</u> 357. CITY: <u>None</u> 358. COUNTY: <u>None</u> 359. STATE: <u>None</u> 360. ZIP CODE: <u>None</u> 361. TELEPHONE: <u>None</u> 362. HOURS OF SERVICE: <u>None</u> 363. NAME OF PHYSICIAN: <u>None</u> 364. ADDRESS OF PHYSICIAN: <u>None</u> 365. CITY: <u>None</u> 366. COUNTY: <u>None</u> 367. STATE: <u>None</u> 368. ZIP CODE: <u>None</u> 369. TELEPHONE: <u>None</u> 370. HOURS OF SERVICE: <u>None</u> 371. NAME OF NURSE: <u>None</u> 372. ADDRESS OF NURSE: <u>None</u> 373. CITY: <u>None</u> 374. COUNTY: <u>None</u> 375. STATE: <u>None</u> 376. ZIP CODE: <u>None</u> 377. TELEPHONE: <u>None</u> 378. HOURS OF SERVICE: <u>None</u> 379. NAME OF DOCTOR: <u>None</u> 380. ADDRESS OF DOCTOR: <u>None</u> 381. CITY: <u>None</u> 382. COUNTY: <u>None</u> 383. STATE: <u>None</u> 384. ZIP CODE: <u>None</u> 385. TELEPHONE: <u>None</u> 386. HOURS OF SERVICE: <u>None</u> 387. NAME OF PHYSICIAN: <u>None</u> 388. ADDRESS OF PHYSICIAN: <u>None</u> 389. CITY: <u>None</u> 390. COUNTY: <u>None</u> 391. STATE: <u>None</u> 392. ZIP CODE: <u>None</u> 393. TELEPHONE: <u>None</u> 394. HOURS OF SERVICE: <u>None</u> 395. NAME OF NURSE: <u>None</u> 396. ADDRESS OF NURSE: <u>None</u> 397. CITY: <u>None</u> 398. COUNTY: <u>None</u> 399. STATE: <u>None</u> 400. ZIP CODE: <u>None</u> 401. TELEPHONE: <u>None</u> 402. HOURS OF SERVICE: <u>None</u> 403. NAME OF DOCTOR: <u>None</u> 404. ADDRESS OF DOCTOR: <u>None</u> 405. CITY: <u>None</u> 406. COUNTY: <u>None</u> 407. STATE: <u>None</u> 408. ZIP CODE: <u>None</u> 409. TELEPHONE: <u>None</u> 410. HOURS OF SERVICE: <u>None</u> 411. NAME OF PHYSICIAN: <u>None</u> 412. ADDRESS OF PHYSICIAN: <u>None</u> 413. CITY: <u>None</u> 414. COUNTY: <u>None</u> 415. STATE: <u>None</u> 416. ZIP CODE: <u>None</u> 417. TELEPHONE: <u>None</u> 418. HOURS OF SERVICE: <u>None</u> 419. NAME OF NURSE: <u>None</u> 420. ADDRESS OF NURSE: <u>None</u> 421. CITY: <u>None</u> 422. COUNTY: <u>None</u> 423. STATE: <u>None</u> 424. ZIP CODE: <u>None</u> 425. TELEPHONE: <u>None</u> 426. HOURS OF SERVICE: <u>None</u> 427. NAME OF DOCTOR: <u>None</u> 428. ADDRESS OF DOCTOR: <u>None</u> 429. CITY: <u>None</u> 430. COUNTY: <u>None</u> 431. STATE: <u>None</u> 432. ZIP CODE: <u>None</u> 433. TELEPHONE: <u>None</u> 434. HOURS OF SERVICE: <u>None</u> 435. NAME OF PHYSICIAN: <u>None</u> 436. ADDRESS OF PHYSICIAN: <u>None</u> 437. CITY: <u>None</u> 438. COUNTY: <u>None</u> 439. STATE: <u>None</u> 440. ZIP CODE: <u>None</u> 441. TELEPHONE: <u>None</u> 442. HOURS OF SERVICE: <u>None</u> 443. NAME OF NURSE: <u>None</u> 444. ADDRESS OF NURSE: <u>None</u> 445. CITY: <u>None</u> 446. COUNTY: <u>None</u> 447. STATE: <u>None</u> 448. ZIP CODE: <u>None</u> 449. TELEPHONE: <u>None</u> 450. HOURS OF SERVICE: <u>None</u> 451. NAME OF DOCTOR: <u>None</u> 452. ADDRESS OF DOCTOR: <u>None</u> 453. CITY: <u>None</u> 454. COUNTY: <u>None</u> 455. STATE: <u>None</u> 456. ZIP CODE: <u>None</u> 457. TELEPHONE: <u>None</u> 458. HOURS OF SERVICE: <u>None</u> 459. NAME OF PHYSICIAN: <u>None</u> 460. ADDRESS OF PHYSICIAN: <u>None</u> 461. CITY: <u>None</u> 462. COUNTY: <u>None</u> 463. STATE: <u>None</u> 464. ZIP CODE: <u>None</u> 465. TELEPHONE: <u>None</u> 466. HOURS OF SERVICE: <u>None</u> 467. NAME OF NURSE: <u>None</u> 468. ADDRESS OF NURSE: <u>None</u> 469. CITY: <u>None</u> 470. COUNTY: <u>None</u> 471. STATE: <u>None</u> 472. ZIP CODE: <u>None</u> 473. TELEPHONE: <u>None</u> 474. HOURS OF SERVICE: <u>None</u> 475. NAME OF DOCTOR: <u>None</u> 476. ADDRESS OF DOCTOR: <u>None</u> 477. CITY: <u>None</u> 478. COUNTY: <u>None</u> 479. STATE: <u>None</u> 480. ZIP CODE: <u>None</u> 481. TELEPHONE: <u>None</u> 482. HOURS OF SERVICE: <u>None</u> 483. NAME OF PHYSICIAN: <u>None</u> 484. ADDRESS OF PHYSICIAN: <u>None</u> 485. CITY: <u>None</u> 486. COUNTY: <u>None</u> 487. STATE: <u>None</u> 488. ZIP CODE: <u>None</u> 489. TELEPHONE: <u>None</u> 490. HOURS OF SERVICE: <u>None</u> 491. NAME OF NURSE: <u>None</u> 492. ADDRESS OF NURSE: <u>None</u> 493. CITY: <u>None</u> 494. COUNTY: <u>None</u> 495. STATE: <u>None</u> 496. ZIP CODE: <u>None</u> 497. TELEPHONE: <u>None</u> 498. HOURS OF SERVICE: <u>None</u> 499. NAME OF DOCTOR: <u>None</u> 500. ADDRESS OF DOCTOR: <u>None</u> 501. CITY: <u>None</u> 502. COUNTY: <u>None</u> 503. STATE: <u>None</u> 504. ZIP CODE: <u>None</u> 505. TELEPHONE: <u>None</u> 506. HOURS OF SERVICE: <u>None</u> 507. NAME OF PHYSICIAN: <u>None</u> 508. ADDRESS OF PHYSICIAN: <u>None</u> 509. CITY: <u>None</u> 510. COUNTY: <u>None</u> 511. STATE: <u>None</u> 512. ZIP CODE: <u>None</u> 513. TELEPHONE: <u>None</u> 514. HOURS OF SERVICE: <u>None</u> 515. NAME OF NURSE: <u>None</u> 516. ADDRESS OF NURSE: <u>None</u> 517. CITY: <u>None</u> 518. COUNTY: <u>None</u> 519. STATE: <u>None</u> 520. ZIP CODE: <u>None</u> 521. TELEPHONE: <u>None</u> 522. HOURS OF SERVICE: <u>None</u> 523. NAME OF DOCTOR: <u>None</u> 524. ADDRESS OF DOCTOR: <u>None</u> 525. CITY: <u>None</u> 526. COUNTY: <u>None</u> 527. STATE: <u>None</u> 528. ZIP CODE: <u>None</u> 529. TELEPHONE: <u>None</u> 530. HOURS OF SERVICE: <u>None</u> 531. NAME OF PHYSICIAN: <u>None</u> 532. ADDRESS OF PHYSICIAN: <u>None</u> 533. CITY: <u>None</u> 534. COUNTY: <u>None</u> 535. STATE: <u>None</u> 536. ZIP CODE: <u>None</u> 537. TELEPHONE: <u>None</u> 538. HOURS OF SERVICE: <u>None</u> 539. NAME OF NURSE: <u>None</u> 540. ADDRESS OF NURSE: <u>None</u> 541. CITY: <u>None</u> 542. COUNTY: <u>None</u> 543. STATE: <u>None</u> 544. ZIP CODE: <u>None</u> 545. TELEPHONE: <u>None</u> 546. HOURS OF SERVICE: <u>None</u> 547. NAME OF DOCTOR: <u>None</u> 548. ADDRESS OF DOCTOR: <u>None</u> 549. CITY: <u>None</u> 550. COUNTY: <u>None</u> 551. STATE: <u>None</u> 552. ZIP CODE: <u>None</u> 553. TELEPHONE: <u>None</u> 554. HOURS OF SERVICE: <u>None</u> 555. NAME OF PHYSICIAN: <u>None</u> 556. ADDRESS OF PHYSICIAN: <u>None</u> 557. CITY: <u>None</u> 558. COUNTY: <u>None</u> 559. STATE: <u>None</u> 560. ZIP CODE: <u>None</u> 561. TELEPHONE: <u>None</u> 562. HOURS OF SERVICE: <u>None</u> 563. NAME OF NURSE: <u>None</u> 564. ADDRESS OF NURSE: <u>None</u> 565. CITY: <u>None</u> 566. COUNTY: <u>None</u> 567. STATE: <u>None</u> 568. ZIP CODE: <u>None</u> 569. TELEPHONE: <u>None</u> 570. HOURS OF SERVICE: <u>None</u> 571. NAME OF DOCTOR: <u>None</u> 572. ADDRESS OF DOCTOR: <u>None</u> 573. CITY: <u>None</u> 574. COUNTY: <u>None</u> 575. STATE: <u>None</u> 576. ZIP CODE: <u>None</u> 577. TELEPHONE: <u>None</u> 578. HOURS OF SERVICE: <u>None</u> 579. NAME OF PHYSICIAN: <u>None</u> 580. ADDRESS OF PHYSICIAN: <u>None</u> 581. CITY: <u>None</u> 582. COUNTY: <u>None</u> 583. STATE: <u>None</u> 584. ZIP CODE: <u>None</u> 585. TELEPHONE: <u>None</u> 586. HOURS OF SERVICE: <u>None</u> 587. NAME OF NURSE: <u>None</u> 588. ADDRESS OF NURSE: <u>None</u> 589. CITY: <u>None</u> 590. COUNTY: <u>None</u> 591. STATE: <u>None</u> 592. ZIP CODE: <u>None</u> 593. TELEPHONE: <u>None</u> 594. HOURS OF SERVICE: <u>None</u> 595. NAME OF DOCTOR: <u>None</u> 596. ADDRESS OF DOCTOR: <u>None</u> 597. CITY: <u>None</u> 598. COUNTY: <u>None</u> 599. STATE: <u>None</u> 600. ZIP CODE: <u>None</u> 601. TELEPHONE: <u>None</u> 602. HOURS OF SERVICE: <u>None</u> 603. NAME OF PHYSICIAN: <u>None</u> 604. ADDRESS OF PHYSICIAN: <u>None</u> 605. CITY: <u>None</u> 606. COUNTY: <u>None</u> 607. STATE: <u>None</u> 608. ZIP CODE: <u>None</u> 609. TELEPHONE: <u>None</u> 610. HOURS OF SERVICE: <u>None</u> 611. NAME OF NURSE: <u>None</u> 612. ADDRESS OF NURSE: <u>None</u> 613. CITY: <u>None</u> 614. COUNTY: <u>None</u> 615. STATE: <u>None</u> 616. ZIP CODE: <u>None</u> 617. TELEPHONE: <u>None</u> 618. HOURS OF SERVICE: <u>None</u> 619. NAME OF DOCTOR: <u>None</u> 620. ADDRESS OF DOCTOR: <u>None</u> 621. CITY: <u>None</u> 622. COUNTY: <u>None</u> 623. STATE: <u>None</u> 624. ZIP CODE: <u>None</u> 625. TELEPHONE: <u>None</u> 626. HOURS OF SERVICE: <u>None</u> 627. NAME OF PHYSIC	
--	--

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13470

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 707 Murdock Road				d. STREET ADDRESS 707 Murdock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodora Middle Boude Last Boude				4. DATE OF DEATH Month December Day 13 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1885		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rome, Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathaniel H. Shaw				14. MOTHER'S MAIDEN NAME Mary Crowther			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Miss Katherine S. Boude, 707 Murdock Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-16-60		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, 1050 York Road, Towson 4, Md				24a. REC'D BY REGISTRAR DATE DEC 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13471

CERTIFICATE OF DEATH

13433

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2817 ONYX Rd</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>1 2817 ONYX Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Samuel T BOWEN</u>		4. DATE OF DEATH <u>Dec 11 1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboree</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beckleysville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Bowen</u>			14. MOTHER'S MAIDEN NAME <u>Lydia Fair</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-07-6693A Mrs Dennis C. Shanahan</u>		17. INFORMANT <u>2817 ONYX Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>182.1</u> DUE TO IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Adenocarcinoma of Bronchus</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>87 weeks</u> <u>6 mos?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>Generalized debilitation</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dec 11 to Dec 10</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>8/10/60</u> to <u>Dec 11, 1960</u> , that (II) (we) last saw the deceased alive on <u>8/10/60</u> and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank T. Kasir Jr</u>		22b. DATE SIGNED <u>12/13/60</u>		22c. PHYSICIAN'S NAME (Type) <u>FRANK T KASIR JR</u>			
22d. ADDRESS <u>9005 Harford Rd. Baltimore 14</u>		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/14/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>			
23d. LOCATION (City, town or county) (State) <u>Baltimore Co Md</u>		25a. REC'D BY REGISTRAR <u>DA DEC 14 '60</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health.

VR A15 (4)
 15M 9/60

25481

1948



UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
FEDERAL BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

12345

12345

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Time of death: [illegible]
8. Cause of death: [illegible]
9. Place of death: [illegible]
10. Signature of physician: [illegible]
11. Signature of registrar: [illegible]
12. Date of registration: [illegible]

CERTIFICATE OF DEATH

13435

Reg. Dist. No.

13473

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 24yr7mth17days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle W. Last Boyle		4. DATE OF DEATH Month December Day 26 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months 71 Days 71 Hours 71 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager		10b. KIND OF BUSINESS OR INDUSTRY warehouse	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew J. Boyle		14. MOTHER'S MAIDEN NAME Jennie Koontz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1956 to Dec. 26, 1960 , that I last saw the deceased alive on Dec. 26, 1960 , and that death occurred at 8:00p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED 12-27-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/60	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Culpeper, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Clara Funeral Home, Culpeper, Va.		ADDRESS to R. S. Smith & Co. Catonsville Md.	
24a. REC'D BY REGISTRAR DEC 28 1960		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. CITY		8. COUNTY		9. STATE		10. ZIP CODE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGY		20. SIGNATURE OF OTHER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERGY		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF CLERGY		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF CLERGY		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF CLERGY		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGY		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF CLERGY		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF CLERGY		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF CLERGY		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF CLERGY		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF CLERGY		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF CLERGY		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF CLERGY		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGY		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF CLERGY		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF CLERGY		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF CLERGY		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

COL IN US A

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. DATE OF DEATH
6. PLACE OF DEATH
7. CITY
8. COUNTY
9. STATE
10. ZIP CODE
11. OCCUPATION
12. CAUSE OF DEATH
13. MANNER OF DEATH
14. SIGNATURE OF PHYSICIAN
15. SIGNATURE OF REGISTRAR
16. SIGNATURE OF WITNESS
17. SIGNATURE OF DECEASED
18. SIGNATURE OF NEXT OF KIN
19. SIGNATURE OF CLERGY
20. SIGNATURE OF OTHER
21. SIGNATURE OF DECEASED
22. SIGNATURE OF NEXT OF KIN
23. SIGNATURE OF CLERGY
24. SIGNATURE OF OTHER
25. SIGNATURE OF OTHER
26. SIGNATURE OF DECEASED
27. SIGNATURE OF NEXT OF KIN
28. SIGNATURE OF CLERGY
29. SIGNATURE OF OTHER
30. SIGNATURE OF OTHER
31. SIGNATURE OF DECEASED
32. SIGNATURE OF NEXT OF KIN
33. SIGNATURE OF CLERGY
34. SIGNATURE OF OTHER
35. SIGNATURE OF OTHER
36. SIGNATURE OF DECEASED
37. SIGNATURE OF NEXT OF KIN
38. SIGNATURE OF CLERGY
39. SIGNATURE OF OTHER
40. SIGNATURE OF OTHER
41. SIGNATURE OF DECEASED
42. SIGNATURE OF NEXT OF KIN
43. SIGNATURE OF CLERGY
44. SIGNATURE OF OTHER
45. SIGNATURE OF OTHER
46. SIGNATURE OF DECEASED
47. SIGNATURE OF NEXT OF KIN
48. SIGNATURE OF CLERGY
49. SIGNATURE OF OTHER
50. SIGNATURE OF OTHER
51. SIGNATURE OF DECEASED
52. SIGNATURE OF NEXT OF KIN
53. SIGNATURE OF CLERGY
54. SIGNATURE OF OTHER
55. SIGNATURE OF OTHER
56. SIGNATURE OF DECEASED
57. SIGNATURE OF NEXT OF KIN
58. SIGNATURE OF CLERGY
59. SIGNATURE OF OTHER
60. SIGNATURE OF OTHER
61. SIGNATURE OF DECEASED
62. SIGNATURE OF NEXT OF KIN
63. SIGNATURE OF CLERGY
64. SIGNATURE OF OTHER
65. SIGNATURE OF OTHER
66. SIGNATURE OF DECEASED
67. SIGNATURE OF NEXT OF KIN
68. SIGNATURE OF CLERGY
69. SIGNATURE OF OTHER
70. SIGNATURE OF OTHER
71. SIGNATURE OF DECEASED
72. SIGNATURE OF NEXT OF KIN
73. SIGNATURE OF CLERGY
74. SIGNATURE OF OTHER
75. SIGNATURE OF OTHER
76. SIGNATURE OF DECEASED
77. SIGNATURE OF NEXT OF KIN
78. SIGNATURE OF CLERGY
79. SIGNATURE OF OTHER
80. SIGNATURE OF OTHER
81. SIGNATURE OF DECEASED
82. SIGNATURE OF NEXT OF KIN
83. SIGNATURE OF CLERGY
84. SIGNATURE OF OTHER
85. SIGNATURE OF OTHER
86. SIGNATURE OF DECEASED
87. SIGNATURE OF NEXT OF KIN
88. SIGNATURE OF CLERGY
89. SIGNATURE OF OTHER
90. SIGNATURE OF OTHER
91. SIGNATURE OF DECEASED
92. SIGNATURE OF NEXT OF KIN
93. SIGNATURE OF CLERGY
94. SIGNATURE OF OTHER
95. SIGNATURE OF OTHER
96. SIGNATURE OF DECEASED
97. SIGNATURE OF NEXT OF KIN
98. SIGNATURE OF CLERGY
99. SIGNATURE OF OTHER
100. SIGNATURE OF OTHER

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13436

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1015, Cummings Ave		d. STREET ADDRESS 1015 Cummings Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELOY		4. DATE OF DEATH Month December 3,		Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1931	9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Pleasant Brooks		14. MOTHER'S MAIDEN NAME Margaret Burts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number and date of service)		17. INFORMANT Address Margaret B. Alsup 3016 Ascension Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds of head. 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in head			
20c. TIME OF INJURY Month, Day, Year 6:45 A 12/3/ 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Catonsville	(County) Baltimore	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 3, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/7/1960	22c. NAME OF CEMETERY OR CREMATORY Mount Calvary		22d. LOCATION (City, town, or country) (State) Arundel Co. Md.
23. FUNERAL DIRECTOR ADDRESS Isaiah L. Brown & Son 108 W. Montgomery		24a. REC'D BY REGISTRAR DEC 7 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

VS. A15ME
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. His pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
OF NEW YORK

1937

Catskill

1015. Cummings Ave

UNION

Dec. 1, 1937

Police Station

1015. Cummings Ave

1015. Cummings Ave

1015. Cummings Ave

1015. Cummings Ave

1015. Cummings Ave

1015. Cummings Ave

1015. Cummings Ave

1015. Cummings Ave

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1 ~~1~~ ~~2~~

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13475

CERTIFICATE OF DEATH

13437

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
c. LENGTH OF STAY IN 1b 7 Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (12)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 723 E. Belvedere Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last NORMAN EUGENE BROOKS, JR.				4. DATE OF DEATH Month Day Year December 5 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1922	
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Electronics		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Norman E. Brooks, Sr.				14. MOTHER'S MAIDEN NAME Ida Fox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 219-18-7521			
17. INFORMANT Clinical Records				Address VAH, Baltimore 18, Md. FORT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL SCARRING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. CONGESTION, VISCERA ARTERIOSCLEROSIS, GENERALIZED, MODERATE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGENITAL ABSENCE, LEFT KIDNEY 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 29, 1960 , to December 5, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 5, 1960 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. 22a. SIGNATURE Fredrick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. 22b. DATE SIGNED 12/5/60 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1960		23c. NAME OF CEMETERY OR CREMATORY Saint Marys (Hampden)		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace F. Burgee				25a. REC'D BY REGISTRAR DEC 7 '60		25b. REGISTRAR'S SIGNATURE Charles L. Fournier	

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 13476
 CERTIFICATE OF DEATH

13438

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 1 mo. 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Larry Last Brown				4. DATE OF DEATH Month 12 Day 4 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1955		9. AGE (In years lost birthday) yrs. 5	IF UNDER 1 YEAR Months 5 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph William Brown				14. MOTHER'S MAIDEN NAME Ruth Inez Koch Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rosewood Records Owings Mills, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, acute DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) mental deficiency DUE TO (c) Cerebral spastic in infantile paralysis with tetraplegia, microcephaly, and							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) mental deficiency							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Owings Mills, Maryland		(County)		(State)	
21. I certify that HE (this hospital) attended the deceased from 11-1-1960 to 12-4-1960 that HE (we) last saw the deceased alive on 12-4-1960 , and that death occurred at 1:00 AM, from the causes and on the date stated above.							
22a. SIGNATURE Edward J. Mathews				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edward J. Mathews, M.D.				22d. ADDRESS Rosewood State Training School Owings Mills, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-60		23c. NAME OF CEMETERY OR CREMATORY Arlington Mt.		23d. LOCATION (City, town, or county) (State) Arlington VA	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517 11th St SE Wash DC				25a. REC'D BY REGISTRAR DEC 8 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

1948

CERTIFICATE OF DEATH

1948

Blank certificate form with faint lines and text, including fields for name, date, and cause of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13477

13439

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 717 South Ann Street, BALTIMORE 31 d. STREET ADDRESS 717 South Ann Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle S. Last BRULINSKI				4. DATE OF DEATH Month December Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1918	
9. AGE (In years lost birthday) 42 yrs.		IF UNDER 1 YEAR Months 4 Days 22		IF UNDER 24 HRS. Hours 42 Min. 42			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter				10b. KIND OF BUSINESS OR INDUSTRY Meat		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Stansislaus				14. MOTHER'S MAIDEN NAME Mary Kotula			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 213-09-8960			
17. INFORMANT Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYELOID LEUKEMIA 204.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) EDEMA OF THE LUNGS DUE TO (c) 1 DAY INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 10, 1960 to December 11, 1960 , that (I) (we) last saw the deceased alive on Dec. 11, 1960 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE SIGNED 12/12/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/60		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Weber and Sons, 401 S. Chester St. Balto. Md.				25a. REC'D BY REGISTRAR DEC 15 '60		25b. REGISTRAR'S SIGNATURE Caroline S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1913

CERTIFICATE OF DEATH

1887

THIS IS TO CERTIFY THAT on the _____ day of _____ 19____
at _____
I, _____
of the County of _____ State of _____
do hereby certify that _____
born _____
died _____
at _____
cause of death _____
attested by _____
at _____
this _____ day of _____ 19____

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13478 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13440

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO Co.	c. LENGTH OF STAY IN 1b 10 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md. 55	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LOSH RAVEN BLVD		d. STREET ADDRESS 1639 MUSSALA ROAD.	
3. NAME OF DECEASED (Type or print) ANNA		4. DATE OF DEATH Month DEC Day 23 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 22, 1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME HERMAN LINDER	
14. MOTHER'S MAIDEN NAME LINA HALLERMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-30-7130		17. INFORMANT BERNHARD BUCHAL Address 1639 MUSSALA RD #4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Insufficiency (c) DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 26, 1960	22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM.
22d. LOCATION (City, town, or county) (State) BALTIMORE Co. Md.		23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road #6 Md	
24a. REC'D BY REGISTRAR DEC 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
090

CERTIFICATE OF DEATH

13441

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 16	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forest Haven Nursing Home		d. STREET ADDRESS 3314 W. North Avenue	
3. NAME OF DECEASED (Type or print) SADIE SHIPLEY BUCK		4. DATE OF DEATH Month Day Year December 31 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Irving Buck		14. MOTHER'S MAIDEN NAME Henrietta Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Nettie Harroll-14 Edmondson Ridge Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebral-Vascular Accident DUE TO (b) Arterio Sclerotic Cardio-Vascular Disease DUE TO (c) Pulmonary Edema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/31, 1960, to 1/1/31, 1961, that (I) (we) last saw the deceased alive on 12/31, 1960, and that death occurred at 1:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE John H. Shaw		22b. DATE SIGNED 1/1/61	
22c. PHYSICIAN'S NAME (Type) John H. Shaw		22d. ADDRESS 5808 Edmondson Ave. Balt-28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons		24. ADDRESS Balt-17, Md.	
25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE Charles E. Hines	

12131

12131

NEW YORK, N.Y.

RECEIVED

RECEIVED

Wm. S. Taylor, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13442**

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GLENN L MARTINS BALTO. 20				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER ESSEX MD. d. STREET ADDRESS 415 RIVERSIDE RD. (21) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAUL FRANCIS BUGOSH First Middle Last			4. DATE OF DEATH DEC 13 1960 Month Day Year				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11-11-11		9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLENN L MARTINS			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LORD MARYLAND.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME PAUL BUGOSH				
14. MOTHER'S MAIDEN NAME ANNA BUGOSH			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				
16. SOCIAL SECURITY NO.			17. INFORMANT WIFE (SAME AS ABOVE) Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis			DATE SIGNED 12/14/60				
EXAMINER'S NAME (Type) M.B. DAVIS MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 12-15-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY ST. ANN'S CEMETERY			
22d. LOCATION (City, town, or county) AVILTON		(State) MARYLAND.					
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly			ADDRESS 418 Eastern Blvd. (21)				
24a. REC'D BY REGISTRAR DEC 16 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kinn					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF JURY		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	

1

13481

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13443

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 4 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 3116 HARFORD ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS WILLIAM BURKE				4. DATE OF DEATH Month Day Year DEC 12 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JAMES E BURKE				14. MOTHER'S MAIDEN NAME ALMEDA ROSSEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-30-5377		17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) HEART FAILURE DUE TO HYPERTENSIVE ARTERIO SCLEROTIC CARDIO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) VASCULAR DISEASE DUE TO (c) 4 YEARS				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-5 19 56 , to 12-11 19 60 , that (I) (we) lost the deceased alive on 12-9 19 60 , and that death occurred 4:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE Walter T. Kees				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/12/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES				22d. ADDRESS COCKEYSVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-14-60		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) 3310 Taylor Avenue	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				25a. REC'D BY REGISTRAR DATE DEC 13 '60		25b. REGISTRAR'S SIGNATURE William S. Finner	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13444

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN lb 19 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 707 Carysbrook Rd., Pikesville 8		d. STREET ADDRESS 707 Carysbrook Rd.	
3. NAME OF DECEASED (Type or print) Alice Olivia Butts		4. DATE OF DEATH Dec. 30, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1904
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Baltio. Co. Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul H. Gessford		14. MOTHER'S MAIDEN NAME Alice Pryor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-2943	
17. INFORMANT Mr. Roger E. Butts		Address Pikesville 8, Md. 707 Carysbrook Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) None			INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> None	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D.D. Caples, MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR Jan 3 '61	
ADDRESS Pikesville 8, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13483

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balt</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1001 W. Joppa Rd. Towson, Md.</i>		d. STREET ADDRESS <i>1001 W. Joppa Rd. 1</i>	
3. NAME OF DECEASED (Type or print) <i>(Sister) Mary Agnes Calkins</i>		4. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 21 - 1902</i>
9. AGE (In years last birthday) <i>58</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Religious</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Missionary</i>	
11. BIRTHPLACE (State or foreign country) <i>New York, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Calkins</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Lawler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Sr. Mary Fidelis</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per the far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, metastatic</i> DUE TO <i>Carcinoma, Adenoma, Kidney</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>180X</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1960</i> to <i>date</i> , 19 <i>1960</i> , that I last saw the deceased alive on <i>1960</i> , and that death occurred at <i>6:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Everett D. Jones</i>		ADDRESS (Street, city or town, state) <i>101 E. Biddle St. Balto, Md.</i>	
PHYSICIAN'S NAME (Type) <i>EVERETT D. JONES</i>		DATE SIGNED <i>12/29/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/30/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Convent Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>1001 W. Joppa Rd. Towson, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Vernon Lemmon</i>		ADDRESS <i>4611 Park Heights, Balto, Md.</i>	
24a. REC'D BY REGISTRAR <i>JAN 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• • • • •

C

5

• \rightarrow \rightarrow \rightarrow

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Narra Middle V. Last Carrick		4. DATE OF DEATH Month December Day 13 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown Wilbur E. Carter		14. MOTHER'S MAIDEN NAME unknown Elizabeth Soper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown No		16. SOCIAL SECURITY NO. 212-09-1111	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 2 , 19 60 , to Dec. 13 , 19 60 , that I last saw the deceased alive on Dec. 13 , 19 60 , and that death occurred at 11:55p.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsl		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12-14-60	
PHYSICIAN'S NAME (Type) Stella Wachsl, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 17, 1960	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Le Vernon Lemmon		24a. REC'D BY REGISTRAR DEC 15 '60	
ADDRESS 4611 Park Heights, Balto.		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13447

13485

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glenarden</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stoney Batter Road</u>		d. STREET ADDRESS <u>Stoney Batter Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gouldie</u> Middle <u>Carter</u> Last <u>Carter</u>		4. DATE OF DEATH <u>December 31</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>	IF UNDER 24 HRS. Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Christian Mast</u>		14. MOTHER'S MAIDEN NAME <u>Mallinda Bears</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>L. M. Carter</u>		Address <u>Stoney Batter Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>422.1</u> DUE TO (c) <u>422.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>55</u> , to <u>12-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-30</u> , 19 <u>60</u> , and that death occurred at <u>2P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dorothy C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md</u> DATE SIGNED <u>12-31-60</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-3-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Fork, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sarahm Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>JAN 5 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1867</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. NAME OF SPOUSE <i>Jane Doe</i>		9. DATE OF MARRIAGE <i>Jan 15 1890</i>		10. PLACE OF MARRIAGE <i>St. Louis, Mo.</i>		11. NAME OF FATHER <i>John Doe</i>		12. NAME OF MOTHER <i>Jane Doe</i>	
13. DATE OF DEATH <i>Jan 15 1912</i>		14. PLACE OF DEATH <i>St. Louis, Mo.</i>		15. CAUSE OF DEATH <i>Heart Disease</i>		16. MANNER OF DEATH <i>Natural</i>		17. SIGNATURE OF PHYSICIAN <i>John Doe</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF SPOUSE <i>Jane Doe</i>		21. SIGNATURE OF FATHER <i>John Doe</i>		22. SIGNATURE OF MOTHER <i>Jane Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>Jane Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13448

Reg. Dist. No.

13486

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> c. LENGTH OF STAY IN 1b <u>4</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1812 Yakona</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> d. STREET ADDRESS <u>1812 YAKONA</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Howard Cassidy</u> First <u>John</u> Middle <u>Howard</u> Last <u>Cassidy</u>		4. DATE OF DEATH <u>Dec 24 1960</u> Month <u>Dec</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7 1899</u> yrs. <u>61</u>
9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>	11. BIRTHPLACE (State or foreign country) <u>Ind</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Cassidy</u>	
14. MOTHER'S MAIDEN NAME <u>Clara Davis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-01-5525</u>		17. INFORMANT <u>Wife</u> Address <u>1812 Yakona</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure, Congestive</u> DUE TO <u>Cor. Pulmonale</u> Conditions, if any, which gave rise to immediate cause (b) <u>Ca lung c metastasis</u> DUE TO <u>Ca lung c metastasis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>2+ mos.</u> <u>8-10 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/22</u> , 19 <u>60</u> , to <u>12/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>60</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		ADDRESS (Street, city or town, state) <u>9005 HARFORD Rd.</u> DATE SIGNED <u>12/24/60</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK</u>		BALTO 14 MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>ELKIDGE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 YORK RD. BALTO 12</u>		24a. REC'D BY REGISTRAR <u>DEC 27 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Travis</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-1-48

REG. NO. 10-1-48

DECEASED NAME JAMES EARL RAY		SEX MALE	
DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALA.	
OCCUPATION MEMBER OF CONGRESS		MARITAL STATUS SINGLE	
PLACE OF DEATH BALTIMORE, MD.		TIME OF DEATH 11:57 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. EDWARD BROWN		SIGNATURE OF REGISTRAR J. EDWARD BROWN	
CITY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201	

1
100
703
M
514
I
0
1
VS A15 (4)
15M 10/57
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13487

CERTIFICATE OF DEATH

Reg. Dist. No.

14573

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 21yr10mth11days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eli (Ely Cica) Middle Cico Last Cico		4. DATE OF DEATH Month December Day 27 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? Yugoslavia	
13. FATHER'S NAME Saul Cico		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records; SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 55 , to Dec. 27 , 19 60 , that I last saw the deceased alive on Dec. 27 , 19 60 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-27-60			
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-31-61		22b. DATE THEREOF 1-31-61	
22c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		DATE FEB 2 '61	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13488

CERTIFICATE OF DEATH

13449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALDWIN</u>		c. LENGTH OF STAY IN 1b <u>39 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SWEETAIR ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WALLACE</u> Last <u>CLARK</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 24, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER, OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>Gladesprings VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Chalmers Clark</u>		14. MOTHER'S MAIDEN NAME <u>MARY JOSEPHINE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-9738</u>	
17. INFORMANT <u>WALTER LEO CLARK (SON)</u>		Address <u>SWEETAIR ROAD, BALDWIN, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR OCCLUSION</u> <u>3324</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUGUST</u> , 19 <u>59</u> , to <u>DECEMBER 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>DECEMBER 15</u> , 19 <u>60</u> , and that death occurred at <u>12:32 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry L. McCorkle</u>		ADDRESS (Street, city or town, state) <u>JARRETSVILLE PIKE, PHOENIX MD</u> DATE SIGNED <u>12/17/60</u>	
PHYSICIAN'S NAME (Type) <u>HENRY L. MCCORKLE</u>		<u>JARRETSVILLE PIKE, PHOENIX MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/20/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORK METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>FORK MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u> ADDRESS <u>Jarrettsville Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 21 60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Fries</u>	

CERTIFICATE OF DEATH

1848

PLACE OF DEATH ...		MARRIAGE ...	
SEX ...		AGE ...	
DATE OF DEATH ...		TIME OF DEATH ...	
PLACE OF BIRTH ...		DATE OF BIRTH ...	
NAME OF DECEASED ...		NAME OF MOTHER ...	
NAME OF FATHER ...		NAME OF SPOUSE ...	
NAME OF CHILDREN ...		NAME OF SIBLINGS ...	
NAME OF NEAREST RELATIVE ...		NAME OF PHYSICIAN ...	
NAME OF BURIAL PLACE ...		NAME OF MINISTER ...	
NAME OF WITNESSES ...		NAME OF REGISTRAR ...	

This certificate is to be filled out by the Registrar of the County or City in which the death occurred. It is to be filled out as soon as possible after the death, and is to be signed by the Registrar, and by the Minister of the Gospel, or by the Physician, or by the nearest relative of the deceased. It is to be filed in the office of the Registrar, and is to be preserved for a period of ten years.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

13489
13450
Item 9 Filed 12-21-60 et

Maryland STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr8mth27dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Maryland	
d. STREET ADDRESS 907 Ulmstead Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Thomas Last Clements		4. DATE OF DEATH Month December Day 11 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1873
9. AGE (In years lost birth day) 86		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plasterer		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO with Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 4 19 60 , to 12/10/60 19 60 , that (I) (we) last saw the deceased alive on 12/10 19 60 , and that death occurred at 8:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsel		22b. DATE SIGNED 12/11/60	
22c. PHYSICIAN'S NAME (Type) STELLA Wachsel		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-13-60	
23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City, town, or county) (State) Balto Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		25a. REC'D BY REGISTRAR DEC 15 '60	
ADDRESS Pikesville Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF MARRIAGE

1948

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13490 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Item b, telephone call—John Burns Sons 12/25/60 cac														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>County Office Building</u>					d. STREET ADDRESS <u>17712 Greenview Terrace</u>									
3. NAME OF DECEASED (Type or print) <u>Harvey Eugene Cline</u>					4. DATE OF DEATH <u>December 16, 1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1915</u>		9. AGE (In years last birthday) <u>45</u> yrs.						
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering Dept. Cl.</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Metro Dist.</u>					11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>Harvey E. Cline, Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Alice S. Brady</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Family Records</u>				
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-</u> (c) <u>Renal Vascular Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					DATE SIGNED <u>12/16/60</u>									
					Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Dec. 19, 1960</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Sater's Baptist Cem.</u>					22d. LOCATION (City, town, or country) (State) <u>Lutherville, Balto. Co., Md.</u>									
23. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>DEC 22 '60</u>									
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>									

1952

1-1-1952

1-1-1952

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13452

13491

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkton</i>		c. LENGTH OF STAY IN 1b <i>3 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>York Rd.</i>		d. STREET ADDRESS <i>1 York Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>HARVEY</i> First <i>COLLINS</i> Middle Last		4. DATE OF DEATH <i>Dec. 28</i> Month <i>1960</i> Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 17, 1892</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boat Factory</i>	
11. BIRTHPLACE (State or foreign country) <i>Sneedsville, Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Collins</i>		14. MOTHER'S MAIDEN NAME <i>Mahalia Ray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, account down) <i>No</i>		16. SOCIAL SECURITY NO. <i>12-31-60</i>	
17. INFORMANT <i>Mrs. Helen Davis, Parkton, Md.</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>general debility</i> <i>223X</i> DUE TO <i>Spinal cord tumor</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>5 yrs</i> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-27</i> to <i>12-28</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>12-27</i> 19 <i>60</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>A. M. France</i>		22b. DATE SIGNED <i>12/28/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>		22d. ADDRESS <i>PARKTON, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-31-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Stablersville Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Parkton, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Paul Hartenstein, New Freedom, Pa.</i>		25a. REC'D BY REGISTRAR <i>DEC 30 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Paul S. Kline</i>			

12423

CERTIFICATE OF DEATH

12423

STATE OF NEW YORK
COUNTY OF [illegible]

[Faint, mostly illegible text, likely a form for a death certificate, possibly containing fields for name, age, date of death, and cause of death.]

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13453

13492

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS RFD #9, Box 411	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRWIN Middle G. Last COURTNEY		4. DATE OF DEATH Month December Day 17 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1889
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail - Meat		10b. KIND OF BUSINESS OR INDUSTRY Meat Packing	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Courtney		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 216-32-8013	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Md - FORT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Thrombosis Right Middle Cerebral Artery - Duration about 2 weeks			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 12, 1960 to Dec. 17, 1960 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on Dec. 17, 1960 , and that death occurred at P.M. , from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles E. Rowan</i>		22b. DATE SIGNED 12/17/60	
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN, M.D.		22d. ADDRESS VAH, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-21-60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore Maryland	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc. Baltimore, Md.		25a. REC'D BY REGISTRAR DEC 21 '60	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>

1

BP

1843

STATE OF NEW YORK
IN SENATE
JANUARY 18, 1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

1843

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

<div style="display: flex; justify-content: space-between;"> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 13431 </div> <div> CERTIFICATE OF DEATH </div> <div> 13454 </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			d. STREET ADDRESS <u>3021 Dundalk Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Abram Allen Cox</u>					4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1960</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 15 1891</u>		9. AGE (In years lost birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>millwright</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Cox</u>					14. MOTHER'S MAIDEN NAME <u>Bertie Ambrose</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>James A Cox</u>			Address <u>3021 Dundalk Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 12/24/1960</u> to <u>12/24</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12/24/1960</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>David H. Andrew</u>					22b. DATE SIGNED <u>12/27/60</u>				
22c. PHYSICIAN'S NAME (Type) <u>David H. Andrew</u>					22d. ADDRESS <u>23 Dundalk Ave Dundalk</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>12/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto National Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave</u>					25a. REC'D BY REGISTRAR <u>DEC 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>		

DEC 29 '60

Arthur S. Hanes

13453

CERTIFICATE OF DEATH

13431



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13493

CERTIFICATE OF DEATH

13455

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - PIKESVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - PIKESVILLE			
c. LENGTH OF STAY IN 1b LIFE							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CRADOCK LANE				d. STREET ADDRESS CRADOCK LANE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ARTHUR First Middle Last				4. DATE OF DEATH DECEMBER 9 1960 Month Day Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 29, 1869	
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS CRADOCK				14. MOTHER'S MAIDEN NAME SALLIE CARROLL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT			
				ARTHUR WYATT 1510 LOCUST AVE. RUXTON MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) Purkin coronary 1938.							INTERVAL BETWEEN ONSET AND DEATH 10 hours 30 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Apr. 3 1935 to Dec 9 1960 , that (I) lost saw the deceased alive on Dec 8 1960 and that death occurred at 8:45 PM from the causes and on the date stated above.							
22a. SIGNATURE F. C. Williams				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type or print) F. C. Williams				22d. ADDRESS Pikesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 12, 1960		23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS CHURCH CEMETERY		23d. LOCATION (City, town, or county) (State) GARRISON, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS CO.				25a. REC'D BY REGISTRAR DEC 14 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

10403

CEP HPC/40 OF DEATH

10403

SEP 1 69

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13456

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS 308 Regester Ave. 12			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM LEE CROMWELL				4. DATE OF DEATH Month Day Year Dec. 31, 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Apr. 13, 1911	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Hardware		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Herbert Cromwell				14. MOTHER'S MAIDEN NAME Mildred Lee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.2				16. SOCIAL SECURITY NO. 213-05-4956			
17. INFORMANT Mr. Josias J. Cromwell				Address Cockeysville, Md. Ashland Rd. /			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 12/31/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan. 3, 1961		22c. NAME OF CEMETERY OR CREMATORY New Cathedral	
22d. LOCATION (City, town, or country) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR Wm. Cook-Towson, Inc.				ADDRESS 1050 York Rd. 4		24a. REC'D BY REGISTRAR DATE JAN 4 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

100-100000

1-100000

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

300 Regester Ave. 12

x

Dec. 31, 1950

CHROMIUM

THE

WILLIAM

x April 1, 1951

White

Male

U.S.A.

Virginia

Baltimore

Seaman

Mildred Lee

James Herbert Cromwell

W.S.

Age

James H. Cromwell, Maryland

Cockeysville

Baltimore, Md.

Jan. 1, 1951 New Technical

Serial

Am. Book Co., Inc. 1000 York St. 4

CERTIFICATE OF DEATH

13457

Reg. Dist. No.

13495

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto Co</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood Sanatorium Towson 4, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>E.</u> Last <u>Csisztu</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 6, 1910</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A. Balto.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Paul Kadosius</u>	
14. MOTHER'S MAIDEN NAME <u>Eva Mafonis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216 10 2493</u>		17. INFORMANT <u>Joseph Csisztu, 1930 Altavue Rd. Catonsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO <u>802X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-14</u> , 19 <u>60</u> , to <u>12-26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-26-60</u> , 19 <u>60</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton B. Kress</u> M.D.		ADDRESS (Street, city or town, state) <u>Eudowood Sanatorium Towson, Md.</u>	
DATE SIGNED <u>DEC 28 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>
22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witke F.D. 4101 Edmondson Ave.</u>		24. REC'D BY REGISTRAR <u>DEC 28 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Witke F.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12485

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1895		BALTIMORE, MD.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
LABORER		HEART DISEASE		NATURAL		HOSPITAL		JAN 20 1940	
PREVIOUS ILLNESS		SYMPTOMS		TREATMENT		PHYSICIAN		HOSPITAL	
NONE		PAIN IN CHEST		DRUGS		DR. HARRIS		HARRIS HOSPITAL	
DATE OF EXAMINATION		BY WHOM EXAMINED		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		OFFICIAL USE	
JAN 20 1940		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

13496

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13458

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>White Hall Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> d. STREET ADDRESS <u>White Hall Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Garnetta R. Curry</u>		4. DATE OF DEATH <u>Dec. 18</u> 19 <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Felix B. Cordray</u>		14. MOTHER'S MAIDEN NAME <u>Martha Finch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Stirling Curry, White Hall, Md. R. 2</u>	
17. INFORMANT <u>Mr. Stirling Curry, White Hall, Md. R. 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1957</u> to <u>Dec 18, 1960</u> , that (I) (we) lost saw the deceased alive on <u>Dec 17, 1960</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u>		22b. DATE SIGNED <u>12/18/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>Parkton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-21-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>DEC 22 '60</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

13497

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13459

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS R.F.D. # 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Fairbairn Davidson		4. DATE OF DEATH Month Day Year Dec. 6 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Davidson		14. MOTHER'S MAIDEN NAME Maria Tilghman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420 IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Sept. 1960 to Dec. 1960, that (I) (we) last saw the deceased alive on Dec. 3 1960, and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED 12/6/60	
22c. PHYSICIAN'S NAME (Type) Robert Mahon		22d. ADDRESS 602 E. Joppa Road Towson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-1960	
23c. NAME OF CEMETERY OR CREMATORY St Mary's Cem		23d. LOCATION (City, town, or county) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. G. L. + Sons		25a. REG'D BY REGISTRAR DEC 8 1960	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1910

1. Name of deceased: *John J. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1910*

5. Time of death: *10:30 AM*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Signature of physician: *Dr. J. H. Jones*

9. Signature of registrar: *Wm. H. Smith*

10. Signature of undertaker: *John D. Smith*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1914 Crafton Avenue				d. STREET ADDRESS 1914 Crafton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK BROWN DAVIS				4. DATE OF DEATH Month December Day 28 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Davis				14. MOTHER'S MAIDEN NAME Elizabeth Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-9540		17. INFORMANT D.L. Davis Address 7816 Scholar Rd., Balto. 22			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) A-S- + Hypertensive C-V Disease (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE MB Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/31/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
				22d. LOCATION (City, town, or county) Baltimore Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 30 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

17132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JOHN J. SMITH		2. SEX MALE		3. AGE 45		4. RACE WHITE	
5. DATE OF DEATH 1918		6. TIME OF DEATH 10:00 AM		7. PLACE OF DEATH HOME		8. STREET 1234 N. E. ST.	
9. CITY BALTIMORE		10. COUNTY JOHNS HOPKINS		11. STATE MARYLAND		12. ZIP CODE 21201	
13. OCCUPATION CLERK		14. MARITAL STATUS MARRIED		15. EDUCATION HIGH SCHOOL		16. RELIGION CATHOLIC	
17. CAUSE OF DEATH HEART DISEASE		18. MANNER OF DEATH NATURAL		19. SIGNATURE OF EXAMINER J. H. SMITH		20. SIGNATURE OF WITNESS J. H. SMITH	
21. SIGNATURE OF DECEASED J. H. SMITH		22. SIGNATURE OF NEXT OF KIN J. H. SMITH		23. SIGNATURE OF CLERK J. H. SMITH		24. SIGNATURE OF JURY J. H. SMITH	
25. SIGNATURE OF JURY J. H. SMITH		26. SIGNATURE OF JURY J. H. SMITH		27. SIGNATURE OF JURY J. H. SMITH		28. SIGNATURE OF JURY J. H. SMITH	
29. SIGNATURE OF JURY J. H. SMITH		30. SIGNATURE OF JURY J. H. SMITH		31. SIGNATURE OF JURY J. H. SMITH		32. SIGNATURE OF JURY J. H. SMITH	
33. SIGNATURE OF JURY J. H. SMITH		34. SIGNATURE OF JURY J. H. SMITH		35. SIGNATURE OF JURY J. H. SMITH		36. SIGNATURE OF JURY J. H. SMITH	
37. SIGNATURE OF JURY J. H. SMITH		38. SIGNATURE OF JURY J. H. SMITH		39. SIGNATURE OF JURY J. H. SMITH		40. SIGNATURE OF JURY J. H. SMITH	
41. SIGNATURE OF JURY J. H. SMITH		42. SIGNATURE OF JURY J. H. SMITH		43. SIGNATURE OF JURY J. H. SMITH		44. SIGNATURE OF JURY J. H. SMITH	
45. SIGNATURE OF JURY J. H. SMITH		46. SIGNATURE OF JURY J. H. SMITH		47. SIGNATURE OF JURY J. H. SMITH		48. SIGNATURE OF JURY J. H. SMITH	
49. SIGNATURE OF JURY J. H. SMITH		50. SIGNATURE OF JURY J. H. SMITH		51. SIGNATURE OF JURY J. H. SMITH		52. SIGNATURE OF JURY J. H. SMITH	
53. SIGNATURE OF JURY J. H. SMITH		54. SIGNATURE OF JURY J. H. SMITH		55. SIGNATURE OF JURY J. H. SMITH		56. SIGNATURE OF JURY J. H. SMITH	
57. SIGNATURE OF JURY J. H. SMITH		58. SIGNATURE OF JURY J. H. SMITH		59. SIGNATURE OF JURY J. H. SMITH		60. SIGNATURE OF JURY J. H. SMITH	
61. SIGNATURE OF JURY J. H. SMITH		62. SIGNATURE OF JURY J. H. SMITH		63. SIGNATURE OF JURY J. H. SMITH		64. SIGNATURE OF JURY J. H. SMITH	
65. SIGNATURE OF JURY J. H. SMITH		66. SIGNATURE OF JURY J. H. SMITH		67. SIGNATURE OF JURY J. H. SMITH		68. SIGNATURE OF JURY J. H. SMITH	
69. SIGNATURE OF JURY J. H. SMITH		70. SIGNATURE OF JURY J. H. SMITH		71. SIGNATURE OF JURY J. H. SMITH		72. SIGNATURE OF JURY J. H. SMITH	
73. SIGNATURE OF JURY J. H. SMITH		74. SIGNATURE OF JURY J. H. SMITH		75. SIGNATURE OF JURY J. H. SMITH		76. SIGNATURE OF JURY J. H. SMITH	
77. SIGNATURE OF JURY J. H. SMITH		78. SIGNATURE OF JURY J. H. SMITH		79. SIGNATURE OF JURY J. H. SMITH		80. SIGNATURE OF JURY J. H. SMITH	
81. SIGNATURE OF JURY J. H. SMITH		82. SIGNATURE OF JURY J. H. SMITH		83. SIGNATURE OF JURY J. H. SMITH		84. SIGNATURE OF JURY J. H. SMITH	
85. SIGNATURE OF JURY J. H. SMITH		86. SIGNATURE OF JURY J. H. SMITH		87. SIGNATURE OF JURY J. H. SMITH		88. SIGNATURE OF JURY J. H. SMITH	
89. SIGNATURE OF JURY J. H. SMITH		90. SIGNATURE OF JURY J. H. SMITH		91. SIGNATURE OF JURY J. H. SMITH		92. SIGNATURE OF JURY J. H. SMITH	
93. SIGNATURE OF JURY J. H. SMITH		94. SIGNATURE OF JURY J. H. SMITH		95. SIGNATURE OF JURY J. H. SMITH		96. SIGNATURE OF JURY J. H. SMITH	
97. SIGNATURE OF JURY J. H. SMITH		98. SIGNATURE OF JURY J. H. SMITH		99. SIGNATURE OF JURY J. H. SMITH		100. SIGNATURE OF JURY J. H. SMITH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13498

CERTIFICATE OF DEATH

Reg. Dist. No.

13461

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ray Middle Glenn Last Decker				4. DATE OF DEATH Month December Day 20 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1897	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY carpentry		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Decker				14. MOTHER'S MAIDEN NAME Edith Puff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 199-07-4731		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease with hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 9, 1960 , to Dec. 20, 1960 , that I last saw the deceased alive on Dec. 20, 1960 , and that death occurred at 9:40p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12-21-60					
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-24-60		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE DEC 27 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kneel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

WILLIAM BROWN
JANUARY 1917

NAME OF DECEASED		SEX		AGE	
WILLIAM BROWN		MALE		45	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JANUARY 15, 1917		BALTIMORE, MARYLAND		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE	
Carpenter		High School		Married	
BIRTH		PARENTS		SPOUSE	
JANUARY 1, 1872		JAMES BROWN & MARY WHITE		MARY WHITE	
PLACE OF BIRTH		DATE OF BIRTH		DATE OF MARRIAGE	
BALTIMORE, MARYLAND		JANUARY 1, 1872		JANUARY 1, 1895	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF MINISTER	
JANUARY 17, 1917		BALTIMORE, MARYLAND		PASTOR BROWN	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF UNDERTAKER	
DR. JAMES BROWN		BROWN & WHITE		BROWN & WHITE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF UNDERTAKER	
[Signature]		[Signature]		[Signature]	
DATE		PLACE		CAUSE	
JANUARY 15, 1917		BALTIMORE, MARYLAND		HEART DISEASE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13499

CERTIFICATE OF DEATH

13462

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Maryland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7700 Greenview Terrace</u>			d. STREET ADDRESS <u>7700 Greenview Terrace</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>CONRADO E. deLAMAR</u>			4. DATE OF DEATH Month Day Year <u>Dec. 28 1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1899</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exporter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cuba</u>	
13. FATHER'S NAME <u>Oscar deLamar</u>			14. MOTHER'S MAIDEN NAME <u>Maria Santa Cruz</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-0823</u>		17. INFORMANT Address <u>Mrs. Frances R. deLamar Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery disease</u> (c) <u>Arterio-sclerotic heart disease</u> DUE TO (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yr.</u> <u>10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 1954</u> to <u>Dec 1960</u> that (I) <u>last</u> saw the deceased alive on <u>8/1/1960</u> , and that death occurred at <u>7A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>N.R. Freeman Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>N.R. FREEMAN, JR.</u>		22d. ADDRESS <u>11W 29th St, Baltimore, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-30-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		23d. LOCATION (City, town or county) (State) <u>Towson Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd. Balto. Md.</u>		25. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VR A15 (4)
15M 9/60

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

13483

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13500

13463

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 808 McKean Street-17 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle --- Last DELAWARE		4. DATE OF DEATH Month December Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1892 9. AGE (In years last birthday) 68 IF UNDER 1 YEAR: Months 68 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Company	
11. BIRTHPLACE (County & State, or foreign country) Clover, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bert C. Coleman		14. MOTHER'S MAIDEN NAME Celia Delaware	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 217-03-7910	
17. INFORMANT Clinical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE PLASMA CELL MYELOMA, WIDE SPREAD 203X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. BRONCHOPNEUMONIA ANEMIA HEART FAILURE	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS UNKNOWN 3 MONTHS 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that X (this hospital) attended the deceased from Dec. 29, 1960 , to Dec. 31, 1960 , that X (we) last saw the deceased alive on Dec. 31, 1960 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Armen Bogosian M.D.		22b. DATE SIGNED 1-1-61	
22c. PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M.D.		22d. ADDRESS VAH, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/61	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City, town or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR JAN 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13463

13700

13463

13700

13700

13463

13700

13700

13463

13700

13463

13700

13700

13463

13700

13463

13700

13700

13700

13463

13700

13463

13463

13700

13700

13463

13700

13463

13700

13463

13700

13463

13700

13463

13700

13463

13700

13700

13463

13700

13700

13463

13700

13463

13700

13700

13700

13700

13700

13700

13700

1
#1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13464

13441

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (arbutus)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Arbutus)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1232 Leeds Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle D. Last Delosier		4. DATE OF DEATH Month Dec. Day 11 , Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1903
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laundry route		10b. KIND OF BUSINESS OR INDUSTRY self-employed	
11. BIRTHPLACE (State or foreign country) Ellicott City, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John E. Delosier		14. MOTHER'S MAIDEN NAME Ida M. Mock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 163X	
17. INFORMANT Mildred Delosier		Address 1232 Leeds Terrace #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mitastatic Carcinoma to Spinal Space		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 29 1960 to Dec 11 1960 that (I) (we) last saw the deceased alive on Dec 10 1960 , and that death occurred on Dec 11 1960 at 1:30 M., from the causes and on the date stated above.			
22a. SIGNATURE A. Bradley Daugharthy		22b. DATE SIGNED 12-12-60	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy, M.D.		22d. ADDRESS 1264 Francis Ave. #27	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/60	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DEC 13 '60	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1744

1

126
MS

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13465

13501

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3513 Jo Ann Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle STUART Last DIENER				4. DATE OF DEATH Month December Day 31 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1960		9. AGE (In years last birthday) yrs. 6	IF UNDER 1 YEAR Months 6 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Diener				14. MOTHER'S MAIDEN NAME Gloria Eisenberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mr. Richard Diener- 3513 Jo Ann Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 492X IMMEDIATE CAUSE (a) Pneumonia (Bronchial) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-30 19 60 , to 12-31 19 60 , that (I) (we) lost the deceased alive on 12-30 19 60 , and that death occurred at 7 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Jerome Fineman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jerome Fineman, M. D.				22d. ADDRESS 4004 Liberty Heights Ave. #7			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 1/61		23c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Soll Levinson & Bros. Inc- 6010 Reist Rd				25a. REC'D BY REGISTRAR DATE JAN 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

20 49 25 5xV6

13501

CERTIFICATE OF DEATH

13501

Married

Married

Female

Female

2013 to Ann 2014

2013 to Ann 2014

December 21, 1950

STANLEY DINTZ

WILLIAM

June 6, 1950

White

Male

Bellevue, Maryland

Home

Home

Charles H. Henshaw

Richard J. Henshaw

Mr. Richard Henshaw 2013 to Ann 2014

no

no

Bellevue, Maryland

Home

Jan 1, 1951

Male

Bellevue & Ann, Inc. - 6010 1st St

13502

CERTIFICATE OF DEATH

Reg. Dist. No.

13466

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calhoun</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pella Nova</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 29, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lingsburg Lutheran Home</u>				d. STREET ADDRESS <u>North Bend Rd. (638)</u>			
3. NAME OF DECEASED (Type or print) <u>Maud Dill</u> First Middle Last				4. DATE OF DEATH <u>Dec 6</u> 19 <u>60</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1879</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u>4</u> Min. <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Bald Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Daniel Strube</u>				14. MOTHER'S MAIDEN NAME <u>Mary O'Dougherty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>Records Rvg. Home 6811 Campfield Rd.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio Sclerosis</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 25, 1960</u> to <u>Dec 6, 1960</u> , that I last saw the deceased alive on <u>Dec 1st, 1960</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4108 Liberty Hts Balto. Md 12-6-60</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heemann 6667 Ayford Rd</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kirsch</u>	

CERTIFICATE OF DEATH

1920

No. *1000* of *1920* in the City and County of *New York*

On the *10th* day of *April* 19*20* at *New York* City

John Doe of the County of *New York* and State of *New York*

aged *45* years, of legal age, male sex, of the color of *White*

born at *New York* City, New York, on the *15th* day of *March* 19*75*

and residing at *100 Broadway*, New York City, New York

came to his death as a result of *Heart Disease*

the cause of death being *Coronary Artery Disease*

the immediate cause of death being *Myocardial Infarction*

the disease or condition existing at the time of death being *Coronary Artery Disease*

the disease or condition existing at the time of death being *Coronary Artery Disease*

the disease or condition existing at the time of death being *Coronary Artery Disease*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13503

CERTIFICATE OF DEATH

13467

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY V	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 22 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1570 Moreland Avenue	
3. NAME OF DECEASED (Type or print) CHARLES I. DIXON		4. DATE OF DEATH Month DECEMBER Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/27/14
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 4 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Industry	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Dixon		14. MOTHER'S MAIDEN NAME Aliethia Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 579-05-9695	
17. INFORMANT Clin.Rec.VAH,Balto.Md. Ft.Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA RIGHT LUNG		INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) CARDIAC INSUFFICIENCY		2 WEEKS	
(c) EDEMA OF LUNGS		5 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) DIABETES MELLITUS - 10 YEARS. PORTAL CIRRHOSIS OF LIVER.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that NY (this hospital) attended the deceased from Dec. 6 19 60 to Dec. 28 19 60 , that NY (we) last saw the deceased alive on Dec. 28 19 60 , and that death occurred at 1:05 AM from the causes and on the date stated above.			
22a. SIGNATURE T. R. HOOD		22b. DATE SIGNED 12/28/60	
22c. PHYSICIAN'S NAME (Type) T. R. HOOD, M.D.		22d. ADDRESS VAH, Balto. Md. Ft. Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR JAN 3 '61	
25b. REGISTRAR'S SIGNATURE William S. Piana			

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

12500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
13504
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13468

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balti.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 21 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILANNA Middle S Last DOWDEN		4. DATE OF DEATH Month DEC Day 14 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME DAVID D. HALLER ALBERT DAVIS DOWDEN		14. MOTHER'S MAIDEN NAME MARY C. VOLTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arterio Sclerotic 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Cardio Vascular Disease DUE TO (c) 10 years.		INTERVAL BETWEEN ONSET AND DEATH 10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25 , 1951, to 12-12 , 1960, that (I) (we) last saw the deceased alive on 12-12 , 1960, and that death occurred at 3 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 12/14/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12-16-60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE DEC 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13469

13505

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4yr11mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leo Middle Henry Last Downs		4. DATE OF DEATH Month December Day 28 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 1899
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Henry Downs		14. MOTHER'S MAIDEN NAME Addie Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 24, 19 60 to Dec. 28, 19 60 , that I last saw the deceased alive on Dec. 28, 19 60 , and that death occurred at 9:00 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslers		DATE SIGNED 12-29-60	
PHYSICIAN'S NAME (Type) Stella Wachslers, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/61	22c. NAME OF CEMETERY OR CREMATORY St. George's	22d. LOCATION (City, town, or county) (State) Leonardtown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingly, Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE JAN 4 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

452

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

Item 20 Film 280 1-27-61 ams										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13470									
13506										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore																								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland					c. LENGTH OF STAY IN 1b 5 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 7520 School Ave.										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First MERLE Middle L. Last DYE					4. DATE OF DEATH Month December Day 25 Year 1960																								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1886		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY Shipyard					11. BIRTHPLACE (State or foreign country) Glan Campbell, Penna					12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME Albert Dye					14. MOTHER'S MAIDEN NAME Mary Smith																								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. WW -1 168-03-1491					17. INFORMANT Clinical Records Address VAH, Baltimore 18, Md-FORT HOWARD DIVISION																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9365 FRACTURE, RIGHT HIP Conditions, if any, which gave rise to immediate cause (b) HYPOSTATIC PNEUMONIA (c) DUE TO (c) 9365										INTERVAL BETWEEN ONSET AND DEATH 6 days 48 Hours																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) No Note Fell on ice outside Home																								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12-19 1960 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> While on work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street					20f. (City or town) (County) (State) Balto. Md.														
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																													
ACTUAL SIGNATURE M. B. Davis										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 12/25/60									
EXAMINER'S NAME (Type) MELVIN B. DAVIS, M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 12-28-60					22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery					22d. LOCATION (City, town, or county) (State) Baltimore Maryland														
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. Baltimore, Md.										24a. REC'D BY REGISTRAR DEC 28 '60					24b. REGISTRAR'S SIGNATURE Arthur L. K...														

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13471

13507

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 17 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 Beaumont Ave.,		e. STREET ADDRESS 117 Beaumont Ave.,	
3. NAME OF DECEASED (Type or print) Nannie L. Ehlen		4. DATE OF DEATH Month Dec. Day 15, Year 19 60.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1869
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Ehlen	
14. MOTHER'S MAIDEN NAME Caroline Turpin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Clara E. Gieske 117 Beaumont Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular Disease 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1952 to December 15, 1960 , that I last saw the deceased alive on Dec. 15, 1960 , and that death occurred at 11:30 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul Rd Baltimore 2 Maryland DATE SIGNED 12/16/60			
ACTUAL SIGNATURE John A. Nesbitt		M.D. 1118 St Paul Rd Baltimore 2 Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-17-1960	22c. NAME OF CEMETERY OR CREMATORY Greenmount	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong 3707 W North Ave		24a. REC'D BY REGISTRAR DATE DEC 19 60	24b. REGISTRAR'S SIGNATURE Clara E. Gieske

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13508

CERTIFICATE OF DEATH

Reg. Dist. No.

13472

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mth 5dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 732 Ramsey Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Eichhorst Last Eichhorst		4. DATE OF DEATH Month Dec. Day 10 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1879
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Buckley		14. MOTHER'S MAIDEN NAME Sarah Bower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. none	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterioscl. Cardiovascular Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, mild			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 8 , 19 60 , to 12/10 , 19 60 , that I last saw the deceased alive on 12/10 , 19 60 , and that death occurred at 4 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12/10/60	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sherman Denny		ADDRESS John F. Denny, Inc.	
24a. REC'D BY REGISTRAR DEC 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

8133

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1930

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF CONSTABLE		18. SIGNATURE OF TOWNSHIP CLERK	
19. SIGNATURE OF VOTING CLERK		20. SIGNATURE OF JURY		21. SIGNATURE OF COURT	
22. SIGNATURE OF JUDGE		23. SIGNATURE OF CLERK		24. SIGNATURE OF REGISTRAR	
25. SIGNATURE OF JUDGE		26. SIGNATURE OF CLERK		27. SIGNATURE OF REGISTRAR	
28. SIGNATURE OF JUDGE		29. SIGNATURE OF CLERK		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF JUDGE		32. SIGNATURE OF CLERK		33. SIGNATURE OF REGISTRAR	
34. SIGNATURE OF JUDGE		35. SIGNATURE OF CLERK		36. SIGNATURE OF REGISTRAR	
37. SIGNATURE OF JUDGE		38. SIGNATURE OF CLERK		39. SIGNATURE OF REGISTRAR	
40. SIGNATURE OF JUDGE		41. SIGNATURE OF CLERK		42. SIGNATURE OF REGISTRAR	
43. SIGNATURE OF JUDGE		44. SIGNATURE OF CLERK		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF JUDGE		47. SIGNATURE OF CLERK		48. SIGNATURE OF REGISTRAR	
49. SIGNATURE OF JUDGE		50. SIGNATURE OF CLERK		51. SIGNATURE OF REGISTRAR	
52. SIGNATURE OF JUDGE		53. SIGNATURE OF CLERK		54. SIGNATURE OF REGISTRAR	
55. SIGNATURE OF JUDGE		56. SIGNATURE OF CLERK		57. SIGNATURE OF REGISTRAR	
58. SIGNATURE OF JUDGE		59. SIGNATURE OF CLERK		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF JUDGE		62. SIGNATURE OF CLERK		63. SIGNATURE OF REGISTRAR	
64. SIGNATURE OF JUDGE		65. SIGNATURE OF CLERK		66. SIGNATURE OF REGISTRAR	
67. SIGNATURE OF JUDGE		68. SIGNATURE OF CLERK		69. SIGNATURE OF REGISTRAR	
70. SIGNATURE OF JUDGE		71. SIGNATURE OF CLERK		72. SIGNATURE OF REGISTRAR	
73. SIGNATURE OF JUDGE		74. SIGNATURE OF CLERK		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF JUDGE		77. SIGNATURE OF CLERK		78. SIGNATURE OF REGISTRAR	
79. SIGNATURE OF JUDGE		80. SIGNATURE OF CLERK		81. SIGNATURE OF REGISTRAR	
82. SIGNATURE OF JUDGE		83. SIGNATURE OF CLERK		84. SIGNATURE OF REGISTRAR	
85. SIGNATURE OF JUDGE		86. SIGNATURE OF CLERK		87. SIGNATURE OF REGISTRAR	
88. SIGNATURE OF JUDGE		89. SIGNATURE OF CLERK		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF JUDGE		92. SIGNATURE OF CLERK		93. SIGNATURE OF REGISTRAR	
94. SIGNATURE OF JUDGE		95. SIGNATURE OF CLERK		96. SIGNATURE OF REGISTRAR	
97. SIGNATURE OF JUDGE		98. SIGNATURE OF CLERK		99. SIGNATURE OF REGISTRAR	
100. SIGNATURE OF JUDGE		101. SIGNATURE OF CLERK		102. SIGNATURE OF REGISTRAR	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
RECEIVED
JAN 10 1930
VITAL RECORDS
BUREAU OF VITAL RECORDS
MASSACHUSETTS STATE DEPARTMENT OF HEALTH

13509

Item 2 Film 4277 12-29-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY CALVERT ?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 7 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS Rt. # 3, c/o David Elbert			
3. NAME OF DECEASED (Type or print) First ATRIE Middle LILLIE Last ELLER				4. DATE OF DEATH Month 12 - Day 14 - Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-1880	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 11 Days 1 Hours 0 Min.		11. IF UNDER 24 HRS. Months 11 Days 1 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME			
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME NELSON JOHNSON				14. MOTHER'S MAIDEN NAME MARTHA DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Hospital Records, Mt. Wilson State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 5-23-1960 to 12-14-1960 , that I last saw the deceased alive on 12-14-1960 , and that death occurred at 8:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Newcomer				ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 12-14-60			
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent, Mt. Wilson, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 12/17/60			
22c. NAME OF CEMETERY OR CREMATORY Boehmer Methodist				22d. LOCATION (City, town, or county) Lancaster Pa. (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				ADDRESS Pikesville Md.			
24a. REC'D BY REGISTRAR DEC 19 '60				24b. REGISTRAR'S SIGNATURE C. E. Hanna			

13509

CERTIFICATE OF GRAIN

Shelton, Conn.

Mr. John H. Smith

St. John's Hospital

Hospital, St. John's, N. H.

St. John's Hospital, N. H.

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13510

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13474

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Milford Gardens</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3500 Mayfair Road</u>				d. STREET ADDRESS <u>3500 Mayfair Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Luke</u> Middle <u>-</u> Last <u>Ellis</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13, 1880</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>		IF UNDER 24 HRS. Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng. Mech & Electrical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City-Ret'd.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry J. Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Kate Calvert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Olivia K. Ellis</u>		Address <u>3500 Mayfair Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 15 hrs.</u> <u>since 1952</u> <u>1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> 19 <u>to Dec 11</u> 1960, that (I) (we) last saw the deceased alive on <u>Dec 2</u> 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Gaston Schubert</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Gaston Schubert</u>				22d. ADDRESS <u>1501 Pentridge Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tucker & Sons</u>				ADDRESS <u>Balto 17, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 15 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

1941

CERTIFICATE OF DEATH

1941

1

Dec 11 1940

1940

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13475

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Granite</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Granite - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OLD COURT RD</u>		d. STREET ADDRESS <u>1 OLD COURT RD</u>	
3. NAME OF DECEASED (Type or print) <u>FARISH</u> First Middle Last <u>ESTER</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 17, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>25</u> Hours <u>00</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Book Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James ESTER</u>		14. MOTHER'S MAIDEN NAME <u>CINDY LONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-03-1415</u>	
17. INFORMANT <u>WIFE - MRS ALICE ESTER</u> Address <u>OLD COURT RD GRANITE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>5 Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 12, 1949</u> to <u>Dec 25, 1960</u> that I last saw the deceased alive on <u>Dec 24, 1960</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.		ADDRESS (Street, city or town, state) <u>8204 LIBERTY Rd, BALTIMORE, MD</u>	
DATE SIGNED <u>Dec 28, 1960</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1960</u>	
22c. NAME OF CEMETERY <u>Granite Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Granite Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Rd. Randallstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13512

CERTIFICATE OF DEATH

Reg. Dist. No.

13476

1. PLACE OF DEATH a. COUNTY <i>BALTO.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>V</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		c. LENGTH OF STAY IN 1b <i>9 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shady Nook Home</i>		e. STREET ADDRESS <i>127 S. COLLINS Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>George W. EVANS</i>		4. DATE OF DEATH <i>Dec. 4, 1960</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/17/1879</i>
9. AGE (In years last birthday) <i>81 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SELF EMP.</i>	
11. BIRTHPLACE (State or foreign country) <i>BALTO. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JACOB EVANS</i>		14. MOTHER'S MAIDEN NAME <i>MARY KERN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-07-0059</i>	
17. INFORMANT <i>Mrs. Wilmer N. Hobbs</i>		Address <i>127 S. COLLINS Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio Vascular Disease & Hypertension</i> DUE TO (c) <i>9 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Thrombosis left Side Menioplegia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1952</i> to <i>12/4</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>12/3</i> , 19 <i>60</i> , and that death occurred at <i>4:15 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eliot W. Johnson</i>		ADDRESS (Street, city or town, state) <i>3432 Frederick Ave. Baltimore 29 Md</i>	
PHYSICIAN'S NAME (Type) <i>Eliot W. Johnson</i>		DATE SIGNED <i>12/5/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/7/1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>BALTO. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. TRUMAN Schnab</i>		ADDRESS <i>3512 Frederick Ave. (29)</i>	
24a. REC'D BY REGISTRAR <i>DEC 7 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13513 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13477

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER MD.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER			
c. LENGTH OF STAY IN 1b LIFE				d. STREET ADDRESS 805 WAMPLER ROAD			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 805 WAMPLER RD. #20				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elmer C Ey				4. DATE OF DEATH Month 12 Day 29 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 9-1917	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 43 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coordinator				10b. KIND OF BUSINESS OR INDUSTRY Martin Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Charles Ey				14. MOTHER'S MAIDEN NAME Louise Pocock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 212-01-5207		17. INFORMANT Mrs Ey	
				Address 805 Wampler Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M.B. Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. DAVIS MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 12/31/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/61		22c. NAME OF CEMETERY OR CREMATORY Zion Luthern Cemetery		22d. LOCATION (City, town, or county) (State) Golden Ring Rd. Md.	
23. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd #6 MD.				24a. REC'D BY REGISTRAR JAN 3 61			
				24b. REGISTRAR'S SIGNATURE Wm. S. Thoms			

19511 MEDICAL EXAMINATION CERTIFICATE OF DELIN

19511 MEDICAL EXAMINATION CERTIFICATE OF DELIN

19511 MEDICAL EXAMINATION CERTIFICATE OF DELIN

19511 MEDICAL EXAMINATION CERTIFICATE OF DELIN

19511 MEDICAL EXAMINATION CERTIFICATE OF DELIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
13393
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13478

1. PLACE OF DEATH a. COUNTY <u>Balto. Edgemere</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTA 22 Md.</u>				c. LENGTH OF STAY IN 1b <u>X Edgemere</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2818 Lodge Farm Road (Pope Lane)</u>				d. STREET ADDRESS <u>2818 Lodge Farm Road (Pope Lane)</u>			
3. NAME OF DECEASED (Type or print) <u>Charles M. Farmer</u>				4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucas</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 6, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State, or foreign country) <u> </u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Sanford Farmer</u>				14. MOTHER'S MAIDEN NAME <u>Laura Farmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Johnnie Farmer</u>				Address <u>1321 Freeman St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumo-pneumonia</u> DUE TO <u>Hypertension + Arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Dec 4-60</u> <u>unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>			
20h. (State) <u> </u>				20i. (City or town) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 20, 1960</u> to <u>Dec 9, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 9, 1960</u> , and that death occurred at <u>2:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. H. Thomas</u>				22b. ADDRESS <u>107 N. Main St. Balto 22 Md</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. H. Thomas MD</u>				22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec 12/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>A. A. County Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank T. Elickson</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 13 1960</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>				25c. REGISTRAR'S SIGNATURE <u> </u>			

13412

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

CERTIFICATE OF DEATH

13412

DATE

TIME

PLACE

D

D

may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13514

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13479

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holbrook				c. LENGTH OF STAY IN 1b About 1 Yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ward's Chapel Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Katie Middle Amelia Last Ferrell				4. DATE OF DEATH Month Dec. Day 5, Year 1960			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1873	
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Thomas Davis				14. MOTHER'S MAIDEN NAME Mary Elizabeth Stephens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *****		17. INFORMANT Mrs. Ray Horn Wards Chapel Road, Marriottsville		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 1 19 60 to Dec 5 19 60 that (I) (we) last saw the deceased alive on Dec 5 19 60 and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Wm. E. Martin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM E MARTIN MD				22d. ADDRESS Randallstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/60		23c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery		23d. LOCATION (City, town, or county) (State) Holbrook, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS 8728 Liberty Road		25a. REC'D BY REGISTRAR DATE DEC 12 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

Randallstown, Md.

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13480

Reg. Dist. No.

13433

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 7509 Lange St.				d. STREET ADDRESS 7509 Lange St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Robert Last Fisher				4. DATE OF DEATH Month Dec. Day 24 , Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1906		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance		10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Fisher				14. MOTHER'S MAIDEN NAME Genevieve Pendergast			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army WWII		16. SOCIAL SECURITY NO. 265-07-6610		17. INFORMANT Address Mr. L. J. Voor 7515 Lange St. 24, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cocaine Addiction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-24-60	
EXAMINER'S NAME (Type) Jack C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-1960		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Frederick Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 WISE AVE. 22, Md.				24a. REC'D BY REGISTRAR DATE JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF _____ CITY OF _____		DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	
NAME OF DECEASED _____ SEX _____ AGE _____		DATE OF DEATH _____ TIME OF DEATH _____	
PLACE OF DEATH _____ STREET ADDRESS _____		OCCUPATION _____ SERVICE _____	
CAUSE OF DEATH _____ MANNER OF DEATH _____		MEDICAL HISTORY _____ PRESENT ILLNESS _____	
SIGNATURE OF EXAMINER _____ TITLE _____		SIGNATURE OF WITNESS _____ TITLE _____	
CERTIFICATE OF DEATH I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.		I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of my examination of the body of the deceased.	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13515

CERTIFICATE OF DEATH

13481

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3001-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>92 Days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (14)</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>	
d. STREET ADDRESS <u>2914 Rosalie Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>H.</u> Last <u>FISHER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 16, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital Supplies</u>	
11. BIRTHPLACE (State or foreign country) <u>Dundalk, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter J. Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>216-01-0822A</u>	
17. INFORMANT <u>Clinical Records, VAH, Fort Howard Division</u>		Address <u>Baltimore 18, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Convulsive disorder. Pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 21, 1960</u> to <u>December 22, 1960</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 28, 1960</u> , and that death occurred at <u>7:10 A.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S. Donaldson</u>		22b. DATE <u>12/22/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u>		22d. ADDRESS <u>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/24/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Inc., Dundalk 22</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>			

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13516

CERTIFICATE OF DEATH

13482

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c		c. LENGTH OF STAY IN 1b 3 Mos. 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hazel Middle Marie Last Flannery		4. DATE OF DEATH Month December Day 3 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 214-01-5571	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prolonged C.V.A., Coma 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive, Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 29, 1960 , to December 3, 1960 , that I last saw the deceased alive on December 3, 1960 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED			
ACTUAL SIGNATURE Jose R. Arizaga		M.D. Spring Grove State Hospital	
PHYSICIAN'S NAME (Type) Jose R. Arizaga, M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 6-60	
22c. NAME OF CEMETERY OR CREMATORY New Calverton Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. ...		ADDRESS	
24a. REC'D BY REGISTRAR DEC 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

22185

158

20-5-11, 195-01

ΣΤΑΘΟΣ Σ. ΜΑΝΩ

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13484									
1. PLACE OF DEATH a. COUNTY Baltimore, County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 107 Linden Court					d. STREET ADDRESS 107 Linden Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James E. Frazier					4. DATE OF DEATH Month Day Year December 25, 1960				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1906		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dinwhitty Co., Virginia			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Charles Wesley				14. MOTHER'S MAIDEN NAME Mary Ellen Dickerson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Roberta Frazier 107 Linden Court			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Petersburg, Virginia		20g. (State) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE M. B. Davis EXAMINER'S NAME (Type) M. B. DAVIS M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 12/27/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Petersburg, Virginia			
23. FUNERAL DIRECTOR ADDRESS William A. Jackson Funeral Home Inc. 916 Pa. Ave.					24a. REC'D BY REGISTRAR DEC 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris		

MASSACHUSETTS DEPARTMENT OF REVENUE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13518

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13485

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c. LENGTH OF STAY IN 1b <u>20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>105 Oak St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Friday</u> Last		4. DATE OF DEATH <u>12-20-60</u> Month <u>12</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March-15-1896</u> 9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Savem</u>	
11. BIRTHPLACE (State or foreign country) <u>Papierla Heights Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Friday</u>		14. MOTHER'S MAIDEN NAME <u>Mary Randsome</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>214-12-895</u>	
17. INFORMANT <u>William Friday</u> Address <u>2428 Lodge Farm Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio Vascular</u> <u>422.1</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Disease</u> (c) <u>Disease</u> DUE TO <u>Disease</u> cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>o. m.</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		DATE SIGNED <u>12/22/60</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Erroy O. Wilson</u>		24a. REC'D BY REGISTRAR <u>DEC 22 1960</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			

1951

[Faint, mostly illegible handwritten text and markings on a medical certificate form. The form includes sections for patient information, medical history, and cause of death.]

PHYSICIAN'S SIGNATURE

DATE
TIME

PHYSICIAN'S SIGNATURE

13180

CERTIFICATE OF DEATH

13180

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

13520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		d. STREET ADDRESS Glenarm Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sister Mary Terentia Fuchs		4. DATE OF DEATH Month December Day 11 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1868
9. AGE (In years lost birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME Joseph Fuchs		14. MOTHER'S MAIDEN NAME Barbara Bachmaier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Sister M. Henrica	
17. INFORMANT Glenarm, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 29, 1946 to Dec. 6, 1960 that I lost saw the deceased alive on Dec. 6, 1960 and that death occurred at 4 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Road Towson, Md. DATE SIGNED 12/11/60			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-14-60	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Ziller ADDRESS 901 S. CONKLING ST. BALTO., MD.		24a. REC'D BY REGISTRAR DATE DEC 14 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Ziller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13520

DECEASED
NAME
AGE
SEX
RACE
BIRTH
PLACE
DATE
OCCUPATION
CAUSE
MANNER
PLACE
DATE
TIME
SIGNATURE
DATE
TIME
PLACE
DATE
TIME

1. Name of deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Birth place: _____

6. Date of birth: _____

7. Occupation: _____

8. Cause of death: _____

9. Manner of death: _____

10. Place of death: _____

11. Date of death: _____

12. Time of death: _____

13. Signature of physician: _____

14. Date of signature: _____

15. Time of signature: _____

16. Place of signature: _____

17. Date of filing: _____

18. Time of filing: _____

19. Place of filing: _____

20. Date of registration: _____

21. Time of registration: _____

22. Place of registration: _____

23. Date of burial: _____

24. Time of burial: _____

25. Place of burial: _____

26. Date of cremation: _____

27. Time of cremation: _____

28. Place of cremation: _____

29. Date of interment: _____

30. Time of interment: _____

31. Place of interment: _____

32. Date of exhumation: _____

33. Time of exhumation: _____

34. Place of exhumation: _____

35. Date of reinterment: _____

36. Time of reinterment: _____

37. Place of reinterment: _____

38. Date of removal: _____

39. Time of removal: _____

40. Place of removal: _____

41. Date of return: _____

42. Time of return: _____

43. Place of return: _____

44. Date of disposal: _____

45. Time of disposal: _____

46. Place of disposal: _____

47. Date of final disposition: _____

48. Time of final disposition: _____

49. Place of final disposition: _____

50. Date of final disposition: _____

51. Time of final disposition: _____

52. Place of final disposition: _____

53. Date of final disposition: _____

54. Time of final disposition: _____

55. Place of final disposition: _____

56. Date of final disposition: _____

57. Time of final disposition: _____

58. Place of final disposition: _____

59. Date of final disposition: _____

60. Time of final disposition: _____

61. Place of final disposition: _____

62. Date of final disposition: _____

63. Time of final disposition: _____

64. Place of final disposition: _____

65. Date of final disposition: _____

66. Time of final disposition: _____

67. Place of final disposition: _____

68. Date of final disposition: _____

69. Time of final disposition: _____

70. Place of final disposition: _____

71. Date of final disposition: _____

72. Time of final disposition: _____

73. Place of final disposition: _____

74. Date of final disposition: _____

75. Time of final disposition: _____

76. Place of final disposition: _____

77. Date of final disposition: _____

78. Time of final disposition: _____

79. Place of final disposition: _____

80. Date of final disposition: _____

81. Time of final disposition: _____

82. Place of final disposition: _____

83. Date of final disposition: _____

84. Time of final disposition: _____

85. Place of final disposition: _____

86. Date of final disposition: _____

87. Time of final disposition: _____

88. Place of final disposition: _____

89. Date of final disposition: _____

90. Time of final disposition: _____

91. Place of final disposition: _____

92. Date of final disposition: _____

93. Time of final disposition: _____

94. Place of final disposition: _____

95. Date of final disposition: _____

96. Time of final disposition: _____

97. Place of final disposition: _____

98. Date of final disposition: _____

99. Time of final disposition: _____

100. Place of final disposition: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13435 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b (22)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk (22)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8238 Longpoint Road				d. STREET ADDRESS 1 8238 Longpoint Road			
3. NAME OF DECEASED (Type or print) First Helen Middle Martha Last Garrison				4. DATE OF DEATH Month December Day 5th Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1917	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY War Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Wanhoff				14. MOTHER'S MAIDEN NAME Martha Plitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-09-3863		17. INFORMANT Andrew Garrison		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease DUE TO Disease Conditions, if any, which gave rise to immediate cause (b) Obesity (c) stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 						INTERVAL BETWEEN ONSET AND DEATH 	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 12/6/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/60		22c. NAME OF CEMETERY OR CREMATORY United Evangelical		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR DATE DEC 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 277 12-28-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13489

13521

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2310</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN PINES</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>C.</u> Last <u>GEYER</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891</u> <u>SEPT. 25/1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LITHOGRAPHER-RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Geyer</u>		14. MOTHER'S MAIDEN NAME <u>Cecilia Schultz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Miss Marie Geyer, 120 Westwood Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL - VASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO - VASCULAR DISEASE -</u> (c) <u>MISSEASE -</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/1</u> , 19 <u>58</u> , to <u>12/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>60</u> , and that death occurred at <u>CITIZEN</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 EDWARDS AVE</u>			
PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D. BALTO. MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cems.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connolly F.H. - Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1940

CERTIFICATE OF D.A.H.

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13522

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13490

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 MIDDLE RIVER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 85 Bird River Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARIE A. GODFREY</u>		4. DATE OF DEATH <u>DEC 4 1960</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-01</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wright</u>		14. MOTHER'S MAIDEN NAME <u>Anna ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Husband (Same as above)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal Varicose Hemorrhage</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Liver's Cirrhosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1 1960</u> to <u>Dec 4 1960</u> that (I) (we) last saw the deceased alive on <u>Dec 4 1960</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Cunningham</u> M.D.		22b. DATE SIGNED <u>12/6/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Balts 6 Md</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-7-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 8 '60</u>	
ADDRESS <u>418 Eastern Blvd.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kiser</u>	

1828

RECORDS OF THE

1828

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13523 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13491

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN lb 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Loch Raven Blvd. near Taylor Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1704 NORTH CAROLINE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE HUNT GORSUCH				4. DATE OF DEATH DEC. 17, 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 28, 1896	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Gorsuch				14. MOTHER'S MAIDEN NAME Lillie P. Shoemaker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 216 01-4963		17. INFORMANT Mrs Oscar A. Bartell Jr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Sudden 420 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 12/18/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 21, 60		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		22d. LOCATION (City, town, or country) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR DEC 20 '60			
				24b. REGISTRAR'S SIGNATURE Arthur L. K...			

MEDICAL CERTIFICATION

1952

1952

1952



MASSACHUSETTS DEPARTMENT OF HEALTH

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

1000 SOUTH BROAD STREET, NEW YORK, N.Y.

DANIEL HUNT - CORONER

DATE OF DEATH

Autopsy performed by Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

Dr. J. J. Boyd

MASSACHUSETTS DEPARTMENT OF HEALTH

1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA AIS (4)
ISM 9/59

1
13524
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13492

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 1 Day				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (15) d. STREET ADDRESS 5521 Kennison Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last MILLARD Arnold GORSUCH				4. DATE OF DEATH Month Day Year December 2 19 60											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 15, 1915		9. AGE (In years lost birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman				10b. KIND OF BUSINESS OR INDUSTRY Food Market				11. BIRTHPLACE (State or foreign country) Havre De Grace, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Robert H. Gorsuch				14. MOTHER'S MAIDEN NAME Eva May Miller											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II 717-07-5630				17. INFORMANT Clinical Records Address VAH, Baltimore 18, Md., FORT HOWARD DIVISION							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL PERFORATION, CAUSE UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBROVASCULAR ACCIDENT DUE TO (c) GENERALIZED ARTERIOSCLEROSIS										INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 DAYS UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism and left hemiparesis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Maryland		(State) Maryland			
21. I certify that (this hospital) attended the deceased from December 1, 1960 to December 2, 1960 , that (we) last saw the deceased alive on December 2, 1960 , and that death occurred at 8:55 A. M., from the causes and on the date stated above.															
22a. SIGNATURE Frederick S. Donaldson				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 12/2/60							
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF December 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery		23d. LOCATION (City, town, or county) Baltimore		(State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Inc.				ADDRESS Reisterstown & Waldron Ave.				25a. RECEIVED BY REGISTRAR DEC 5 '60		25b. REGISTRAR'S SIGNATURE Charles S. Hanna					

Pikesville, Md.

1555

1555

1555



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13442
CERTIFICATE OF DEATH

13493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balti			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4837 Carmella Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle C Last Goss				4. DATE OF DEATH Month December Day 31 Year 1960			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1879	
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dietician				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Clark				14. MOTHER'S MAIDEN NAME Henrietta E. (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-07-6030		INFORMANT Address John H. Lampe, 548 Brook Rd., Towson 4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Arterio sclerosis C-V DUE TO (c) Disease C Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH Several weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 27, 1960 to Dec 31, 1960 that I last saw the deceased alive on Dec 31, 1960 , and that death occurred at 538 M , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Cook, Inc.				DATE SIGNED 3033 W. North Ave. Baltimore, Md.			
PHYSICIAN'S NAME (Type) M. Paul Beyerly				PAID 16 W.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-3-61		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE JAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Deceased

Age

Place of Birth

Date of Death

Time of Death

Place of Death

Sex

Color

Marital Status

Occupation

Education

Signature of Physician

Signature of Coroner

Signature of Registrar

For many a year
after a long
illness

Page 1 of 1
Date of Death
1/13/11
1/13/11

TO HOSPITAL

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13525

13494

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN 1b

600 Morris Avenue

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Towson Convalescent Home

d. STREET ADDRESS

Lutherville

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

ELIZABETH VIRGINIA GREASER

4. DATE OF DEATH

December 25, 1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

October 4, 1877

9. AGE (In years last birthday)

83 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles H. Kenny

14. MOTHER'S MAIDEN NAME

Margaret Daley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Family Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Cardiac Failure

INTERVAL BETWEEN ONSET AND DEATH

3 days

4221 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Arterio-sclerotic C-V Disease

DUE TO

(c)

10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1940 to 1960, that (I) (we) last saw the deceased alive on Dec. 23, 1960, and that death occurred at 8 PM, from the causes and on the date stated above.

22a. SIGNATURE

Tos. A. Sedlack

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Tos. A. SEDLACK

22d. ADDRESS

200 W. Penna. Ave Towson 4 Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State)

Burial

Dec. 29, 1960

May's Chapel Cemetery

Timonium, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR DATE

25b. REGISTRAR'S SIGNATURE

John Burns' Sons, Towson, Maryland

DEC 30 '60

Arthur S. Frank

18283

MAINTAINANCE DE L'AVIATION DE L'ARMÉE
MINISTÈRE DE L'AVIATION
CERTIFICATE OF ORIGIN

18283

Description of the aircraft		Date of issue	
Type of aircraft		Date of issue	
Engine		Date of issue	
Propeller		Date of issue	
Landing gear		Date of issue	
Fuel system		Date of issue	
Electrical system		Date of issue	
Communication system		Date of issue	
Navigation system		Date of issue	
Armament		Date of issue	
Other equipment		Date of issue	
Remarks		Remarks	
Signature of the issuing authority		Signature of the receiving authority	
Date of issue		Date of issue	

18283

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Item 18 Film 279
1-17-61 ams

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13495

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1638 Gray Place		d. STREET ADDRESS 1638 Gray Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET Reva Grebos		4. DATE OF DEATH Month Day Year December 21 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1924 AGE (In years last birthday) 37 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wise, VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Bryant		14. MOTHER'S MAIDEN NAME Lelia Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Green Funeral Home		Address Appalachia, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion			
753.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Epileptic seizure			
(c) Cerebral developmental anomaly (Microgyria)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/21/60	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/22/60	
22c. NAME OF CEMETERY OR CREMATORY Wise		22d. LOCATION (City, town, or country) (State) Appalachia, Virginia	
23. FUNERAL DIRECTOR Wm. Cook Inc		24a. REC'D BY REGISTRAR DEC 27 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

THE STATE
OF NEW YORK

1930

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK
1930

ALBANY

ALBANY

ALBANY

ALBANY

ALBANY

ALBANY

ALBANY

December 31, 1930

ALBANY

ALBANY

White

White

White

ALBANY

ALBANY

ALBANY

X

X

12/31/30

ALBANY

ALBANY

TO HOSPITAL by the attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO HOSPITAL by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13526

13496

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 21 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY d. STREET ADDRESS 13410 HOPKINS AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) HARRY JOSEPH GROB		4. DATE OF DEATH DEC. 14 1960		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 17 1895		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE PAINTER				10b. KIND OF BUSINESS OR INDUSTRY GENERAL PAINTING				11. BIRTHPLACE (State or foreign country) BALTIMORE Md.				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ALBERT GROB				14. MOTHER'S MAIDEN NAME MAGGIE WEHR				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 21 8-09-8547				17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNGS (BILATERAL) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMPHYSEMA DUE TO (c) PNEUMOTHORAX																INTERVAL BETWEEN ONSET AND DEATH UNCERTAIN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from NOV. 21, 1960 to DEC 14, 1960 , that (I) (we) last saw the deceased alive on DEC 14, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE Wm. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 12-14-60											
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/17/60				23c. NAME OF CEMETERY OR CREMATORY Lorraine				23d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Licknew & Sons				ADDRESS Baltimore, Md.				25a. REC'D BY REGISTRAR DEC 16 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

15478

CERTIFICATE OF DEATH

1925

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

1883

13437

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 1714 Pinewood Drive				d. STREET ADDRESS 1714 Pinewood Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last John Guzinski				4. DATE OF DEATH Month Day Year December 5, 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1881	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret., Water Dept.		10b. KIND OF BUSINESS OR INDUSTRY City of Baltimore		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Guzinski				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Tekla Snyder 1714 Pinewood Dr. 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC C.V.D.I.S. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 day YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 5, 1960 , to Dec 5, 1960 , that I last saw the deceased alive on Dec 5, 1960 , and that death occurred at 4 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen C. Mackowiak				ADDRESS (Street, city or town, state) DATE SIGNED 6714 HOLABIRDAU BALTIMORE 22 MD. 12-7-60			
PHYSICIAN'S NAME (Type) STEPHEN C. MACKOWIAK				6714 HOLABIRDAU BALTIMORE 22 MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1960		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City, town, or county) (State) German Hill Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA				ADDRESS 7922 Wise Ave. 22. Md.		24a. REC'D BY REGISTRAR DATE DEC 13 '60	
				24b. REGISTRAR'S SIGNATURE Clairmont E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11438

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

11438

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15, 1873		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH Jan 25, 1938	
11. SIGNATURE OF PHYSICIAN J. H. Harris		12. SIGNATURE OF WITNESS J. H. Harris		13. SIGNATURE OF DECEASED J. H. Harris		14. SIGNATURE OF NEXT OF KIN J. H. Harris		15. SIGNATURE OF REGISTRAR J. H. Harris	
16. NAME OF DECEASED JAMES H. HARRIS		17. SEX Male		18. AGE 65		19. DATE OF BIRTH Jan 15, 1873		20. PLACE OF BIRTH Baltimore, Md.	
21. OCCUPATION Carpenter		22. CAUSE OF DEATH Heart Disease		23. MANNER OF DEATH Natural		24. PLACE OF DEATH Home		25. DATE OF DEATH Jan 25, 1938	
26. SIGNATURE OF PHYSICIAN J. H. Harris		27. SIGNATURE OF WITNESS J. H. Harris		28. SIGNATURE OF DECEASED J. H. Harris		29. SIGNATURE OF NEXT OF KIN J. H. Harris		30. SIGNATURE OF REGISTRAR J. H. Harris	

1. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

2. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

3. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

4. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

5. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

6. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

7. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

8. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

9. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

10. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 25th day of January, 1938.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
13528

1
M

OSD

1

Y

1

AP

13490

13528

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 77 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3001-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 618 South Grundy Street (24)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES		First h.H.		Middle HAGEY		Last	
4. DATE OF DEATH December 19 1960		Month December		Day 19		Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1894	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Driving		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland U		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Hagey				14. MOTHER'S MAIDEN NAME Elizabeth Stout			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clinical Rec., VAH, Baltimore 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA WITH ABSCESS FORMATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. BRONCHOGENIC CARCINOMA OF THE LEFT LUNG WITH METASTASES TO THE HILAR MESENTERIC LYMPH NODES, BOTH ADRENALS AND SUBCUTANEOUS TISSUE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from October 23, 1960 , to December 19, 1960 , that (X) (we) last saw the deceased alive on Dec. 19, 1960 , and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE George C. McElpatrick, M.D.				22b. DATE 12/20/60		22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M.D.	
22d. ADDRESS VAH, Baltimore, 18, Md. FT. HOWARD DIVISION				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/60		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore CO. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.F. Hoffmann				25a. REC'D BY REGISTRAR DEC 22 '60		25b. REGISTRAR'S SIGNATURE Clarence F. Hoffman	
25c. ADDRESS 3218 Hudson St. Balto. Md.							

Clarence F. Hoffman, 3218 Hudson St., Balto. Md.

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

12500

CERTIFICATE OF DEATH

12500

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13530

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13501

1. PLACE OF DEATH a. COUNTY BALTIMORE CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 STEVENSON LANE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLEN Middle SARAH Last HAMILTON				4. DATE OF DEATH Month DECEMBER Day 17 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 11, 1916	
9. AGE (In years last birthday) 44 yrs.		10. UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13. FATHER'S NAME THOMAS P. PRATT				14. MOTHER'S MAIDEN NAME CAROLINE PASQUAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-18 19 60 , to 12-18 19 60 , that (I) (we) lost saw the deceased alive on 12-18 19 60 , and that death occurred at 3 P. M. from the causes and on the date stated above.							
22a. SIGNATURE William R. Lumpkin				22b. DATE SIGNED 12-20-60		22c. PHYSICIAN'S NAME (Type) William R. Lumpkin	
22d. ADDRESS 1114 St. Paul St Baltimore Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/20/60		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		23d. LOCATION (City, town, or county) (State) PIKESVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons, Towson Md.				25a. REC'D BY REGISTRAR DATE DEC 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

THESE 2007 111

SUN 302207Z JUL 77

75

71

[[[

41

2/05/95

• 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628,

CERTIFICATE OF DEATH

18581

5071

18581

5071

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13532

13503

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3921 Belvue Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Served as: William WILLIAM Middle HAWKINSON Last HAWKINS			4. DATE OF DEATH Month December Day 30 Year 1960 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
5. SEX MALE 6. COLOR OR RACE Colored 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 8-21-96 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur 10b. KIND OF BUSINESS OR INDUSTRY Chauffeur 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Frank Hawkins 14. MOTHER'S MAIDEN NAME Nellie White		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. WW-1 17. INFORMANT Clin Rec VAH Baltimore 18 Md - Ft Howard Div.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC HYPERTROPHY AND DILATATION WITH CONGESTIVE FAILURE DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA - 4 DAYS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 10 PLUS YEARS		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 3:50 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) December 28, 1960 December 30, 1960		
21. I certify that X (this hospital) attended the deceased from December 28, 1960 to December 30, 1960 , that X (we) last saw the deceased alive on December 30, 1960 , and that death occurred at 3:50 p.m. from the causes and on the date stated above.			22a. SIGNATURE Charles Allen M.D. 22b. DATE SIGNED 12-31-60 22c. PHYSICIAN'S NAME (Type) Charles Allen M.D. 22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/4/61 23c. NAME OF CEMETERY OR CREMATORY Baltimore National 23d. LOCATION (City, town or county) Baltimore (State) Maryland			24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips 1808-10 N Monroe St Baltimore 17 Md 25a. REC'D BY REGISTRAR DATE JAN 3 '61 25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

13303

13303

Baltimore

Baltimore

Baltimore

2 DAYS

old house

1001 Atlantic Street

Religious Administration Hospital

HAMILTON

Served as: William

HAMILTON

William

December 20

61

1-21-50

Colorado

Wife

U.S.A.

Foreign

Chaplain

White White

Frank Hamilton

21-01-5031 Civil War 1861 - 1865

W-1

Yes

CARDIOVASCULAR AND RESPIRATORY DISEASE

CONSTITUTIONAL

HYPERTENSIVE CARDIOVASCULAR DISEASE

UNKNOWN

10 YEARS

RECOMMENDATION - 1 DAY

December 20 1950

December 20 1950

12-21-50

1001 Atlantic Street

Charles Allen

Baltimore

Baltimore

Initial

1001 Atlantic Street

Religious Administration Hospital

Baltimore 17 18

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13533

CERTIFICATE OF DEATH

13504

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b 75 DAYS		d. STREET ADDRESS 227 MIDLAND AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEROEY Middle MCDONALD Last HAYWOOD		4. DATE OF DEATH Month December Day 10 Year 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 15, 1895
9. AGE (In years lost birthday) yrs. 65		10. BIRTHPLACE (State or foreign country) MARYLAND	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAMPLE CARRIER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILLIP HAYWOOD		14. MOTHER'S MAIDEN NAME ELLA JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-1		17. INFORMANT CLIN REC VAH BALTO 18 MD-FT HOWARD DIVISION	
16. SOCIAL SECURITY NO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG WITH METASTASIS TO PANCREAS AND LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X (c) 163X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 26, 1960 to Dec. 10, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 10, 1960 , and that death occurred at 3:12 a.m., from the causes and on the date stated above.			
22a. SIGNATURE ARTHUR T. FAULK		22b. DATE SIGNED 12-10-60	
22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK		22d. ADDRESS M.D. VAH BALTO 18 MD-FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/13/60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR DEC 15 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Finner			

BP

CERTIFICATE OF DEATH

13 411

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13505

13534

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Millers</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Millers</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beckleysville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>B.</u> Last <u>Henry</u>		4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1877</u>
9. AGE (In years (last birthday) yrs. <u>83</u>		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Basting Fuller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D. 7, S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Baublitz</u>		14. MOTHER'S MAIDEN NAME <u>Emma Ensor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-1816</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis region of 4th Ventricle</u> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 d</u> <u>10 y</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular fibrillation 6-8 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Ian</u> , 19 <u>50</u> to <u>Dec. 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 1</u> , 19 <u>60</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beckleysville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hampstead Md. R.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Hertenstein</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '60</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

M

I

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. PERIOD OF ILLNESS		14. PREVIOUS ILLNESS		15. MEDICAL ATTENDANCE	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CORONER		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CORONER		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF CORONER		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF CORONER		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESSES		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF CORONER		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CORONER		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESSES		48. SIGNATURE OF PHYSICIAN		49. SIGNATURE OF CORONER		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESSES		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF CORONER		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESSES		58. SIGNATURE OF PHYSICIAN		59. SIGNATURE OF CORONER		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESSES		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF CORONER		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESSES		68. SIGNATURE OF PHYSICIAN		69. SIGNATURE OF CORONER		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESSES		73. SIGNATURE OF PHYSICIAN		74. SIGNATURE OF CORONER		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESSES		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF CORONER		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESSES		83. SIGNATURE OF PHYSICIAN		84. SIGNATURE OF CORONER		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESSES		88. SIGNATURE OF PHYSICIAN		89. SIGNATURE OF CORONER		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESSES		93. SIGNATURE OF PHYSICIAN		94. SIGNATURE OF CORONER		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESSES		98. SIGNATURE OF PHYSICIAN		99. SIGNATURE OF CORONER		100. SIGNATURE OF REGISTRAR	

RECEIVED
BUREAU OF VITAL STATISTICS
NEW YORK STATE DEPARTMENT OF HEALTH
JAN 10 1910

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13536

13507

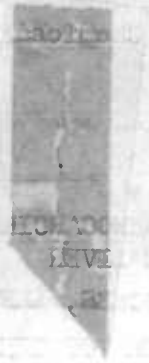
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN lb 42 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 (5) d. STREET ADDRESS 1031 Washington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle ----- Last HICKS		4. DATE OF DEATH Month December Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1896
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Chemical	
11. BIRTHPLACE (State or foreign country) Raleigh, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Hicks		14. MOTHER'S MAIDEN NAME Mary Burney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. VAH, Baltimore 18, Maryland, FORT HOWARD DIVISION	
17. INFORMANT Clinical Records		Address VAH, Baltimore 18, Maryland, FORT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE WITH METASTASIS TO THE LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ABSCISS, LEFT PERIPROSTATIC REGION EDEMA OF THE LUNGS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour .o. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from October 31, 1960 to December 12, 1960 , that (X) (we) last saw the deceased alive on Dec. 12, 1960 , and that death occurred at 12:30 P. M. from the causes and on the date stated above.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 3 DAYS +	
22a. SIGNATURE Frederick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22b. DATE SIGNED 12/13/60 M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick, 1412 E. Preston St., Balto., Maryland		25a. REC'D BY REGISTRAR DEC 19 '60 25b. REGISTRAR'S SIGNATURE Charles S. House	

17707

CERTIFICATE OF DEATH

1853

(1)



13308

CERTIFICATE OF DEATH

1891

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name" and "Age" are faintly visible.]

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Signature" and "Date" are faintly visible.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13509

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u> c. LENGTH OF STAY IN <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V014</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4123 Woodhaven Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Hogue</u> Last <u>Hogue</u>				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-22-1920</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BETHELHEM STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>CAMPBELL CO. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>TAYLOR HOGUE</u>				14. MOTHER'S MAIDEN NAME <u>MARY LU DEARING</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES</u> <u>W.W.2</u>		16. SOCIAL SECURITY NO. <u>229-09-1907</u>		17. INFORMANT <u>U.S. ARMY DISCHARGE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blunt-force head injury</u> 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>822X</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car that overturned at high speed</u>					
20c. TIME OF INJURY Month, Day, Year <u>24</u> Hour <u>12</u> a.m. <u>1225</u> p.m. <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Baltimore - Harford Expressway, Maryland - Pennsylvania Ave</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. Bradley King, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. Bradley King, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>12-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT'L. CEM.</u>	
22d. LOCATION (City, town, or country) <u>BALTO. MD.</u>				22e. (State) <u>BALTO. MD.</u>			
23. FUNERAL DIRECTOR <u>Charles G. Cooper</u>				ADDRESS <u>512 CARROLLTON AV.</u>			
24a. REC'D BY REGISTRAR DATE <u>DEC 28 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thoms</u>			

MEDICAL CERTIFICATION

STATE OF NEW YORK
DEPARTMENT OF HEALTH

18558

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18558

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON, AND IS TO BE SUBMITTED TO THE DEPARTMENT OF HEALTH, ALBANY, NEW YORK, FOR RECORD AND STATISTICAL PURPOSES.

NAME OF DECEASED PERSON: _____
AGE: _____ SEX: _____
DATE OF DEATH: _____ PLACE OF DEATH: _____

CAUSE OF DEATH: _____
MANNER OF DEATH: _____

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

13539

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 Gwynn Lake Drive</u>				d. STREET ADDRESS <u>1 2 Gwynn Lake Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Horne</u>				4. DATE OF DEATH Month Day Year <u>Dec. 18, 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1874</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rooming House</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Horne</u>				14. MOTHER'S MAIDEN NAME <u>Ann Mc Intyre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-36-1969</u>		INFORMANT Address <u>Mr. William Horne- 2 Gwynn Lake Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Broncho-pneumonia</u> DUE TO (c) <u>Hypertensive cardio-vascular dis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>1 day.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>54</u> , to <u>Dec 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>60</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3601 Greenway Baltimore</u> <u>12-28-60</u> ACTUAL SIGNATURE <u>Stephen J Van Lill</u> M.D. PHYSICIAN'S NAME (Type) <u>Stephen J Van Lill MD</u> <u>3601 Greenway Baltimore, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tuckner, Sons Balto 17 Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Wm J. Tuckner</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

13510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

13540

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13511

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3031 Woodside Avenue</u>		d. STREET ADDRESS <u>13031 Woodside Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. William Daniel Howell</u>		4. DATE OF DEATH Month Day Year <u>December 18th 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lloyd M. Howell</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Le Doyen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Annie M. Howell</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Liver and Brain metastases</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Pyelonephritis and Nephrolithiasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-15</u> , 19 <u>60</u> , to <u>12-18</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12-18</u> , 19 <u>60</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. Benson, Jr.</u> M.D.		22b. DATE SIGNED <u>12-19-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. BENSON, JR.</u>		22d. ADDRESS <u>3506 N. CALVERT, BALT. 18, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/21/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>DEC 20 '60</u>	
ADDRESS <u>5395 Harford Road #14</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

John H. Howell

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
<div>13541</div> <div>Item 7 Film G277 12-29-60 et</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>13512</div>									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Manor Road					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville d. STREET ADDRESS Manor Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM					4. DATE OF DEATH Found December 18, 1960				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown		8. DATE OF BIRTH UNKNOWN		9. AGE (in years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man		10b. KIND OF BUSINESS OR INDUSTRY Shoe		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT J.S. EVANS		Address 8802 Harford Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause test. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE W. S. Fisher EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/19/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/22/60		22c. NAME OF CEMETERY OR CREMATORY MT. ZION BAPTIST Cemetery		22d. LOCATION (City, town, or country) (State) Chen Arm Md			
23. FUNERAL DIRECTOR Charles F. Evans & Son ADDRESS 8802 Harford Rd					24a. REC'D BY REGISTRAR DEC 27 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Evans		

MEDICAL CERTIFICATION

15518

15541

THE STATE
OF NEW YORK

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

1

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

DEPT. OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13542

CERTIFICATE OF DEATH

Reg. Dist. No.

13513

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> M		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>N. J.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bayonne</u> <u>67X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>313 Roanoke Dr.</u>		d. STREET ADDRESS <u>204 Boulevard</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>B.</u> Last <u>Hulse</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/77</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>	
13. FATHER'S NAME <u>Norman Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Fox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Mrs Edgar Hulse</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4:20 p.m.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis.</u> DUE TO (c) <u>Coronary Atherosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u> <u>10 da.</u> <u>1071 (3)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-10-</u> 19 <u>60</u> , to <u>12-19-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>12-19-</u> 19 <u>60</u> , and that death occurred at <u>11:57 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>William K. Gallagher</u> M.D.		<u>6209 Frederick Ave.</u> <u>12-20-60</u>			
PHYSICIAN'S NAME (Type) <u>William K. Gallagher M.D.</u>		<u>Baltimore-25, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall & Son Co.</u>		ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

CERTIFICATE OF DEATH

1951

1951

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. RACE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13543 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Items 8 & 9, Film G-279 1/16/61 cag.

13514

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle R. Last HURLEY		4. DATE OF DEATH Month December Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1920
9. AGE (In years last birthday) 38 39 yrs.		10. IF UNDER 1 YEAR Months 38 Days 39 Hours 39 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright		10b. KIND OF BUSINESS OR INDUSTRY Mill	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel J. Hurley		14. MOTHER'S MAIDEN NAME Ruty Davidson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-12-5654	
17. INFORMANT Clin. Records. Vet. Adm. Hosp. Balto. Md. Ft. Howard Div		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157 X IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from Nov. 23 1960 to Dec. 23 1960, that no (we) last saw the deceased alive on Dec. 23 1960, and that death occurred at 4:35 PM from the causes and on the date stated above.			
22a. SIGNATURE Charles E. Rowan		22b. DATE SIGNED 12/23/60	
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN, M.D.		22d. ADDRESS VAH, BALTO. MD. - FT HOWARD DIV	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-27-60	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City, town, or county) (State) Federalsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. FRAMPTON & SON, MAIN ST. FEDERALSBURG, MD.		25a. REC'D BY REGISTRAR DATE DEC 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

1854

STATE OF NEW YORK

1854

County of ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
13544 CERTIFICATE OF DEATH										
Reg. Dist. No. 13515										
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>103 SMITHWOOD AVE.</u>					d. STREET ADDRESS <u>103 SMITHWOOD AVE.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CATHERINE E. HUSTER</u>					4. DATE OF DEATH Month <u>DEC.</u> Day <u>12</u> Year <u>1960</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 16, 1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS-RET.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>FRANK SCHUCHART</u>					14. MOTHER'S MAIDEN NAME <u>JOSEPHINE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Mrs. Charles W. Homler - 103 Smithwood Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Hypertensive cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis - hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diet, calculus, hypertrophic gastritis</u>										
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>6 yrs.</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>57</u> , to <u>Dec. 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 11</u> , 19 <u>60</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1709 Edmonson Ave</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Justinas Kudirka</u> M.D. PHYSICIAN'S NAME (Type) <u>Justinas KUDIRKA, M.D.</u> <u>Catonville, Md.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)				
<u>Burial</u>		<u>12-16-60</u>		<u>Cathedral Cem.</u>		<u>Balto.</u> <u>Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>July Cavanaugh F.H.</u>					ADDRESS <u>Catonville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13545

CERTIFICATE OF DEATH

13516

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>			c. LENGTH OF STAY IN 1b <u>10 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(HOME) Caves Road</u>				d. STREET ADDRESS <u>Caves Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>LINDLEY</u> Last <u>INGRAM</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 10, 1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Univ. Match Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>James E. Ingram</u>				14. MOTHER'S MAIDEN NAME <u>Mary Purnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-07-9872</u>		17. INFORMANT <u>Mary R. Ingram (wife) - Caves Rd., Owings Mills.</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary thrombosis</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1950</u> , to <u>Dec 11, 1960</u> , that I last saw the deceased alive on <u>Dec 10, 1960</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nathan E. Needle</u>		M.D.		ADDRESS (Street, city or town, state) <u>4215 Park Heights Avenue</u>		DATE SIGNED <u>Baltimore, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>NATHAN E. NEEDLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart & Mowen Company, 108 W. North Av., Balt</u>				24a. REC'D BY REGISTRAR <u>DEC 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>RACE</p>	
<p>DATE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>IMMEDIATE CAUSE</p>	
<p>UNDERLYING CAUSE</p>		<p>INTERESTED PARTY</p>	
<p>SIGNATURE OF REGISTRAR</p>		<p>DATE</p>	
<p>LOCAL HEALTH OFFICER</p>		<p>DATE</p>	
<p>STATE HEALTH OFFICER</p>		<p>DATE</p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13546 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13517

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>M.D.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. LENGTH OF STAY IN lb <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WIGHT AVE</u>		d. STREET ADDRESS <u>WIGHT AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN</u> <u>BOSLEY</u> <u>JESSOP</u>		4. DATE OF DEATH Month Day Year <u>DEC</u> <u>18</u> <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-85</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VENEER</u>	
11. BIRTHPLACE (State or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THEAS. BEAVER DAM VENEER MILL, INC.</u>		14. MOTHER'S MAIDEN NAME <u>BETTIE BOSLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>ROGER STENBERSEN</u>	
17. INFORMANT <u>COCKEYSVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND, CALVARIUM</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/18/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/20/60. Burial Sherwood Church Cem</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>COCKEYSVILLE</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Measor & Son 805 N. Calvert St.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 20 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13518

13547

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	c. LENGTH OF STAY IN 1b 84 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Happy Hollow Road		d. STREET ADDRESS Happy Hollow Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AUGUSTUS Middle C. Last JOHNSON		4. DATE OF DEATH Dec. 18, 1960 Month Dec. Day 18 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert H. Mohring (Step-father)	
14. MOTHER'S MAIDEN NAME Eliza (last name unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Lois M. Parks, Happy Hollow Rd, Cockeysville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 9th 1959 , to Dec. 18th 1960 , that I last saw the deceased alive on Dec. 17th 1960 , and that death occurred at 11 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M27 York Rd., TOWSON, Md DATE SIGNED 12/19/60			
ACTUAL SIGNATURE M. K. Quinn		M.D. M27 York Rd., TOWSON, Md	
PHYSICIAN'S NAME (Type) M. KEVIN QUINN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/60	22c. NAME OF CEMETERY OR CREMATORY Fork M.E.	22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Mm. Cook-Towson, York Rd. Towson, Md.		24a. REC'D BY REGISTRAR DATE DEC 20 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13548

CERTIFICATE OF DEATH

Reg. Dist. No.

13519

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V81-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home		d. STREET ADDRESS 811 E. 34th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George		Middle H.		Last Johnson		4. DATE OF DEATH Month Dec. 17,	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years lost birthday) yrs. 89	
9. AGE (In years lost birthday) yrs. 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Spec. Police		11. BIRTHPLACE (State or foreign country) Md. State Racing		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Charles Burton Johnson		14. MOTHER'S MAIDEN NAME Susan Clayton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverticulitis, Colon		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md.	
21. I certify that I attended the deceased from June , 19 47 , to Dec. , 19 60 , that I last saw the deceased alive on Dec 8 , 19 60 , and that death occurred at 10 M, from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) 6011 York Rd. Balt. Md.		23. DATE SIGNED 12/19/60		24. SIGNATURE Arthur S. Thomas	
ACTUAL SIGNATURE Wm. H. Kammer, Jr.		M.D. 6011 York Rd. Balt. Md.		25. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr.		26. REGISTRAR'S SIGNATURE Arthur S. Thomas	
27. BURIAL, CREMATION, REMOVAL (Specify) Burial		28. DATE THEREOF 12/20/60		29. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		30. LOCATION (City, town, or county) (State) Baltimore, Md.	
31. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner, Sons		ADDRESS Balt. Md.		32. REC'D BY REGISTRAR DATE DEC 21 '60		33. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13549

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13520

1. PLACE OF DEATH a. COUNTY <u>BALTB</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES N.H.</u>				d. STREET ADDRESS <u>44 SEQUOIA RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>M. Jones</u> Middle <u>M.</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 1 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CHARLES PETERSON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579146371A</u>		17. INFORMANT <u>FAMILY</u> Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <u>Cerebral arteriosclerosis</u> DUE TO lying cause lost (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yr</u> <u>10 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-3-</u> , 19 <u>59</u> , to <u>12-28-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-27-</u> , 19 <u>60</u> , and that death occurred at <u>8 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Ballager</u> M.D. <u>6209 Frederick Ave.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Ballager, M.D. Baltimore-28</u>				<u>MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLEND, P.D., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Banauer</u> ADDRESS <u>SEVERNA PK.</u>				24a. REC'D BY REGISTRAR <u>JAN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13550

CERTIFICATE OF DEATH

Reg. Dist. No.

13521

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Clarendon Ave</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>209 Reisterstown Road</u>				c. LENGTH OF STAY IN 1b <u>Pikesville 8</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Clarendon Ave.</u> <u>209 Reisterstown Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Jannie</u> Middle <u>Cooksey</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1868</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Deal Island, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Robert Cooksey</u>				14. MOTHER'S MAIDEN NAME <u>Anne E. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>0</u>		17. INFORMANT <u>Mrs. Grace Cecil, 209 Clarendon Ave. #8, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Decubitus ulcers, severe</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>0</u> , 19 <u>60</u> , to <u>12-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>0</u> , 19 <u>60</u> , and that death occurred at <u>10:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Williams</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1632 Reisterstown Road</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>				<u>Pikesville 8, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jessops Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Sparks Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>				ADDRESS <u>6411 Windsor Mill Rd.</u>		24a. REC'D BY REGISTRAR <u>AN 4 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

Consumed dead at 11PM 12/31/60, obtained diagnosis by phone from Dr. Anne Boyce

CERTIFICATE OF DEATH

18500

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Date of death: <u>1900</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Sex: <u>Male</u></p>	
<p>5. Race: <u>White</u></p>		<p>6. Birth date: <u>1855</u></p>	
<p>7. Place of birth: <u>England</u></p>		<p>8. Cause of death: <u>Heart Disease</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Name of informant: <u>John J. Smith</u></p>	
<p>13. Address: <u>123 Main St.</u></p>		<p>14. City: <u>Baltimore</u></p>	
<p>15. State: <u>Maryland</u></p>		<p>16. County: <u>City of Baltimore</u></p>	
<p>17. Signature of physician: <u>[Signature]</u></p>		<p>18. Signature of informant: <u>[Signature]</u></p>	
<p>19. Date of certificate: <u>1900</u></p>		<p>20. Name of registrar: <u>[Signature]</u></p>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
#

13551

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13522

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY 85X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1002 N. Rolling Rd. Shady Nook Nursing Home				d. STREET ADDRESS 3313 Staunton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Ellen Jones				4. DATE OF DEATH Dec. 8/60 19 19			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 13, 1873	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Buck				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1				16. SOCIAL SECURITY NO. Rev. Clarence E. Jones, Jr. 3313 Staunton AVE			
17. INFORMANT Charleston, W. Va.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease (c) Arteriosclerotic cardio-vascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Aug. 2, 1960 , to Dec. 8, 1960 , that (I) (we) last saw the deceased alive on Dec. 8, 1960 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George A. Knipp				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/9/60	
22c. PHYSICIAN'S NAME (Type) George A. Knipp, M. D.				22d. ADDRESS 4116 Edmondson Avenue			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/10/60		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville 8 MD	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave				25a. REC'D BY REGISTRAR DATE DEC 12 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

1853

CHURCH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13443

1

M

13523

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1252 DUNE ROAD</u>				d. STREET ADDRESS <u>11252 DUNE ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie ELIZABETH Kappauf</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 7 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1882</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM HALL</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET SCHIERMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>HENRY KAPPAUF 1252 DUNE ROAD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> 19 to <u>12/7</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12/7</u> 19 <u>60</u> and that death occurred at <u>6AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Hallins</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward S. Hallins</u>				22d. ADDRESS <u>4300 Liberty Hts Av</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		23d. LOCATION (City, town, or county) (State) <u>WOODLAWN Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u>				ADDRESS <u>Francis W. Miller 2101 Frederick Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 9 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

THE

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

13552 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13524

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 6627 Wycombe Way			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6627 Wycombe Way				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth		First		Middle		Last Kafl	
4. DATE OF DEATH Dec. 31,		Month		Day		Year 1960	
5. SEX F.	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/28/93		9. AGE (In years last birthday) 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ANDRE GERSTLE				14. MOTHER'S MAIDEN NAME BARBARA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT 4205 ELDERON AVENUE BALTO. 15, MISS MYRTLE FLAGGS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & congestion 420 } DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King, Jr.				M.D.		DATE SIGNED Jan. 1, 1961	
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/3/61		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY		22d. LOCATION (City, town, or country) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR HENRY SANDER & SONS INC.				ADDRESS BALTIMORE Maryland		24a. REC'D BY REGISTRAR JAN 5 '61	
				24b. REGISTRAR'S SIGNATURE William J. King			

(M)

(X)
(I)

2

BP

NOT FOR
REPRODUCTION

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

1833

13553

CERTIFICATE OF DEATH

Reg. Dist. No.

13525

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. LENGTH OF STAY IN 1b <u>22 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>West Liberty Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>A.</u> Last <u>Keech</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1873</u>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer -</u>		10c. KIND OF BUSINESS OR INDUSTRY <u>Own Farm -</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James A. Keech</u>		14. MOTHER'S MAIDEN NAME <u>Louise Day</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Occlusion</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Arterio Sclerosis</u> DUE TO (c) <u>15 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1955</u> to <u>Dec 5, 1960</u> that I last saw the deceased alive on <u>Dec 5, 1960</u> , and that death occurred at <u>1140 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WILLIAM O. Fulton</u>		Stewartstown Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec 10, 1960</u>	<u>West Liberty Cemetery</u>	<u>White Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		24. REC'D BY REGISTRAR <u>DEC 9 '60</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knap</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

13554

13526

Reg. Dist. No.

1

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13554

13526

Reg. Dist. No.

1

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 50 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERNON Middle C. Last KELLY		4. DATE OF DEATH Month December Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23- 1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min. 62	IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY box factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 215-09-4292	
17. INFORMANT Records: SPRING GROVE STATE HOSPI TAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure & Pleural effusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic rheumatic mitral valvulitis (stenosis) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 7, 1960 to Dec. 26, 1960 , that I last saw the deceased alive on Dec. 26, 1960 , and that death occurred at 6:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED SPRING GROVE STATE HOSPITAL 12-27-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/5/61	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mac Pratt & Son Co		ADDRESS 28	
24a. REC'D BY REGISTRAR DATE JAN 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

THE UNIVERSITY OF CHICAGO

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13555

13527

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>3501-4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Pines</i>		d. STREET ADDRESS <i>3928 Park Heights Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>DORA</i> Middle <i>KERMAN</i> Last <i>KERMAN</i>		4. DATE OF DEATH Month <i>DEC.</i> Day <i>10</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Israel</i>		14. MOTHER'S MAIDEN NAME <i>Shifra</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <i>Rose Badner - daughter</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of cecum with metastases</i> 152.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <i>Aug 12, 1960</i> to <i>Dec 10, 1960</i> , that (I) (we) last saw the deceased alive on <i>Dec 9, 1960</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Abraham B. Hurwitz</i> M.D.		22b. DATE SIGNED <i>12/10/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>ABRAHAM B. HURWITZ MD</i>		22d. ADDRESS <i>3403 GARRISON BLVD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-11-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>		23d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewin</i> ADDRESS <i>2100 Euteria Pl</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 13 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

1953

CERTIFICATE OF DEATH

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and possibly a signature area.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13556

CERTIFICATE OF DEATH

13528

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1563 Glen Keith Blvd</u>		d. STREET ADDRESS <u>1563 Glen Keith Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Katherine A. Kilduff</u>		4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1869</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>	
14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Charles J. Kilduff</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Degenerative Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour e.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> to <u>12/14</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> , 19 <u>60</u> , and that death occurred <u>9:30</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas L. Worsley, Jr.</u>		22b. DATE SIGNED <u>12/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas L. Worsley, Jr. M. D.</u>		22d. ADDRESS <u>2900 Alameda Blvd., Baltimore 18, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 16 '60</u>	
ADDRESS <u>5305 Harford Road #14</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13557

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13529

CERTIFICATE OF DEATH

Item 2 Film 6278 1-10-61 et

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHESAPEAKE Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 11 years & 9 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN	
3. NAME OF DECEASED (Type or print) EMILY First H Middle KLINEFELTER Last		4. DATE OF DEATH DEC 31 19 60 Month Day Year	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 6, 1868
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BUDD STERLING FORD		14. MOTHER'S MAIDEN NAME EMILY ANN HENDRIX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr. Address Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arterio Sclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9 years (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-16 19 49 to 12-30 19 60 , that (I) (we) last saw the deceased alive on 12-30 19 60 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 12/31/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-4-61	
23c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		23d. LOCATION (City, town, or county) (State) North East, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR JAN 4 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles L. Kees	

Downloaded At: 11:53 11 September 2009

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13558

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13530

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 Montrose ave</u>		d. STREET ADDRESS <u>113 Montrose ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Violet M. Koons</u>		4. DATE OF DEATH Month Day Year <u>Jan. 3 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/85</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John K. Quinn</u>		14. MOTHER'S MAIDEN NAME <u>Phuland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Daisy M. Pasho</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular disease - Met to heart to weeks</u> DUE TO <u>179</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer Breast - Metastatic 8/8/54 - 182</u> DUE TO (c) <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10 1960</u> to <u>Dec 31 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 31 1960</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>D. E. W. Koons</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec 31/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. E. W. Koons</u>		22d. ADDRESS <u>1138 Northern Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/6/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Strand Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. J. Ruff + Son Co</u> ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR <u>DEC 7 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneel</u>	

1855

CERTIFICATE OF DEATH

1855

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be a certificate of death, mentioning names and dates.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13531

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2906 Dunran Road				d. STREET ADDRESS 2906 Dunran Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle JEROME Last KOONTZ				4. DATE OF DEATH Month December Day 12 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1913	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 20 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Postoffice		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Joseph Koontz				14. MOTHER'S MAIDEN NAME Margaret C. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 212-07-1886		17. INFORMANT Evelyn M. Koontz Address same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Hypertensive C-v Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR DEC 16 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hana	

1913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		PLACE OF BIRTH	
JAMES H. HARRIS		45		Male		White		Maryland	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE	
1000 North Howard St.		Carpenter		High School		Married		1905	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
Jan 15, 1913		10:30 AM		Home		Heart Disease		Natural	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		FINDINGS		REMARKS	
Jan 15, 1913		11:00 AM		Home		No abnormal findings			
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		FINDINGS		REMARKS	
J. H. Harris		Jan 15, 1913		Home		No abnormal findings			
SIGNATURE OF WITNESS		DATE OF EXAMINATION		PLACE OF EXAMINATION		FINDINGS		REMARKS	
J. H. Harris		Jan 15, 1913		Home		No abnormal findings			
SIGNATURE OF WITNESS		DATE OF EXAMINATION		PLACE OF EXAMINATION		FINDINGS		REMARKS	
J. H. Harris		Jan 15, 1913		Home		No abnormal findings			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

13559
MAY 206 & 21, Film G-277 12/29/60. MB
13532

<p>1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b 15 YRS</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7422 Kenlea Avenue</p>												<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY BAIT MORE</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore</p> <p>d. STREET ADDRESS 7422 Kenlea Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>3. NAME OF DECEASED (Type or print) GEORGE STANLEY LATKA</p>						<p>4. DATE OF DEATH December 21, 19 60</p>																	
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH July 27, 1943</p>		<p>9. AGE (In years last birthday) 17 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>															
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>				<p>11. BIRTHPLACE (State or foreign country) Baltimore, Md</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>													
<p>13. FATHER'S NAME Anthony A. Latka</p>						<p>14. MOTHER'S MAIDEN NAME Clara Bafford</p>																	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)</p>				<p>16. SOCIAL SECURITY NO. None</p>		<p>17. INFORMANT Anthony A. Latka 7422 Kenlea Avenue Address</p>																	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest. DUE TO (b) 778 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)</p>												<p>INTERVAL BETWEEN ONSET AND DEATH</p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>																							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SHOT SELF WITH gun 20-gauge gun.</p>																			
<p>20c. TIME OF INJURY Month, Day, Year 4:30 P.M. 12/21/60</p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) house</p>		<p>20f. (City or town) Baltimore (County) Baltimore (State) Md.</p>															
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>																							
<p>ACTUAL SIGNATURE Wise - Wood</p>				<p>EXAMINER'S NAME (Type) William V. Lovitt, Jr., M. D.</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p>															
<p>DATE SIGNED December 22, 1960</p>				<p>Address (Street, city, town, or county)</p>																			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>				<p>22b. DATE THEREOF Dec 24 1960</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery</p>		<p>22d. LOCATION (City, town, or country) Taylor Ave (State) Md</p>															
<p>23. FUNERAL DIRECTOR Dippel Brothers 7110 Belair Road ADDRESS</p>						<p>24a. REC'D BY REGISTRAR DEC 23 '60</p>		<p>24b. REGISTRAR'S SIGNATURE Arthur L. Kiana</p>															

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK

1884

IN SENATE

1884

AND THREE

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

X

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

THIRTY

CERTIFICATE OF DEATH

Reg. Dist. No. **13533****13560**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, (Owings Mills P.O.)			c. LENGTH OF STAY IN 1b 6 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greenspring & Walnut Aves.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Helena Middle (NMI) Last Laudicina			4. DATE OF DEATH Month December Day 19 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Oreste Frazoni		
14. MOTHER'S MAIDEN NAME Louisa Frandi			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give war or dates of service		
16. SOCIAL SECURITY NO. none			17. INFORMANT Mr. Vincent J. Laudicina, Greenspring & Walnut A.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of cervix with extensive metastases DUE TO (c) metastases					INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 48 Main Street	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from August 21, 19 57 , to December 19 19 60 and that I last saw the deceased alive on December 17, 19 60 , and that death occurred at 2 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main Street		DATE SIGNED 12-19-60	
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.		Reisterstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Dec. 22, 1960	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemmon		ADDRESS 4611 Park Heights, Balto. Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Harris

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAMS & BIRNBAUM

00261

1997-1998

0012-1622/97/0005-0000\$10.00/0

2

• • •

• *Journal of Management Education*, 2000, 24(1), 1-10

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Shady Nook Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 5532 Hutton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last LAURER		4. DATE OF DEATH Month December Day 8 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1894
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6	11. IF UNDER 24 HRS. Hours 6 Min. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Utica, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Laurer		14. MOTHER'S MAIDEN NAME Barbara Ammon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-6834	
17. INFORMANT Mrs. Mary M. Laurer		Address -5532 Hutton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 12 hours 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****	
20c. TIME OF INJURY Month, Day, Year Hour, a. m. p. m. ***** 19	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****	20f. (City or town) (County) (State) *****
21. I certify that I attended the deceased from _____, 19 50 , to December , 19 60 , that I last saw the deceased alive on 8 December , 19 60 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 Dec. 1960			
ACTUAL SIGNATURE <i>Millard T. Traband</i>		DATE SIGNED 9 Dec. 1960	
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr., M.D., 5101 Gwynn Oak Ave. Balt. 7, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/12/1960	22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24a. REC'D BY REGISTRAR DEC 12 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>
23. FUNERAL HOME ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.			

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1333

1333

CENTRAL CITY, OHIO

Ballou

Ballou

Ballou

Ballou

Ballou

Ballou

Ballou

LAUREN

LAUREN

May 20, 1904

May 20, 1904

112

U.S. Govt.

U.S. Govt.

U.S. Govt.

Barbara Ann

Barbara Ann

213-02-8834 Mrs. Mary M. Lott - 2525 Lott St.

No

10 days

10 days

1 year

1 year

11:30

11:30

11:30

11:30

11:30

11:30

11:30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13562

CERTIFICATE OF DEATH

Reg. Dist. No.

13535

1. PLACE OF DEATH a. COUNTY <u>Baltimore 20</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN TB <u>X</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sweetness</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARPER</u> Middle <u>LEAVERTON</u> Last <u>Leaverton</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 26 1889</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>29</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt Construction Building</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>John Leaverton</u>		14. MOTHER'S MAIDEN NAME <u>Ida Cummings</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1000 1</u>	
17. INFORMANT <u>Golden Leaverton</u>		Address <u>541 Bayside Dr</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>332X</u> DUE TO (c) <u>332X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/28</u> , 19 <u>60</u> , to <u>12/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>60</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leonard P Burger</u>		ADDRESS (Street, city or town, state) <u>Fuller Medical - Ridge Rd</u>	
PHYSICIAN'S NAME (Type) <u>Fuller Medical</u>		DATE SIGNED <u>12/30/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Barkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		24a. REC'D BY REGISTRAR <u>212 Dundalk</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u>		DATE <u>JAN 4 '61</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13563 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 228 Ridge Avenue			d. STREET ADDRESS 228 Ridge Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EDWARD ALBERT LORENZ			4. DATE OF DEATH Month December Day 20 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1904		9. AGE (In years last birthday) 56 yrs.
				IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Broker		10b. KIND OF BUSINESS OR INDUSTRY Ford-Griffin Agency		11. BIRTHPLACE (State or foreign country) New York	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Beckley Lorenz			14. MOTHER'S MAIDEN NAME Mary ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 073-01-9335		17. INFORMANT Family Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Renal (c) Vascular Disease					INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/20/60	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 23, 1960	22c. NAME OF CEMETERY OR CREMATORY Bulaney Valley Memorial		22d. LOCATION (City, town, or county) (State) Timonium, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DEC 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG278 1-6-61 et

13564

CERTIFICATE OF DEATH

Reg. Dist. No.

13537

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coxonsville 28</u>		c. LENGTH OF STAY IN 1b <u>2M 7 D</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove St. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Lutins</u> Last <u>2</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-88</u>
9. AGE (In years, months, days) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u>4</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Sidney</u>		14. MOTHER'S MAIDEN NAME <u>Bertha</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Bessie Lutins - same</u>	
17. INFORMANT <u>Bessie Lutins</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breunmania</u> 450.0 DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 17</u> , 19 <u>60</u> , to <u>Dec 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 24</u> , 19 <u>60</u> , and that death occurred at <u>43</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann</u> M.D.		DATE SIGNED <u>Dec 24 1960</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutan Pl</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

720 Fleet St., Balto.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13565

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13538

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3 Cargil Ave.,				d. STREET ADDRESS 2218 W. Fayette St.			
3. NAME OF DECEASED (Type or print) First MARY Middle FRANCES Last LYLES				4. DATE OF DEATH Month December 26, Day 19 Year 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1925	
9. AGE (In years last birthday) 35 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 35 yrs.	
11. BIRTHPLACE (State or foreign country) Mississippi				12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Perry Hughes				14. MOTHER'S MAIDEN NAME Mary Ella Skipwith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give number and date of service)		17. INFORMANT James L. Lyles Address 2218 W. Fayette St., Balto., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: 681X IMMEDIATE CAUSE (e) Septicemia DUE TO suppurative endometritis complicating pregnancy. Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Catonsville Baltimore, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr., M. D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED December 27, 1960		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/30/60		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park.,		22d. LOCATION (City, town, or country) (State) Laurel, Md.	
23. FUNERAL DIRECTOR Robert L. Swodder		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1953

1953

THE PART
OF THE

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13566 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13539

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Parkton</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <i>144 Eaton Place</i>	
3. NAME OF DECEASED (Type or print) <i>Ernest</i>		4. DATE OF DEATH Month <i>12</i> Day <i>25</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>CA</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 10, 1920</i>
9. AGE (In years last birthday) <i>40</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	
IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>na</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Henry Lynch</i>	
14. MOTHER'S MAIDEN NAME <i>Rhoda Dearing</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Clark Moss 144 Eaton Pl. Wash D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Blunt-force head injury</i> 822X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Passenger in car that overturned @ high speed</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>245</i> p.m. <i>12/25/60</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>		20f. (City or town) <i>Baltimore - Harrington Expressway</i> (County) <i>Maryland - Pennsylvania line</i> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W.B. King</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>W. Bradley King Jr.</i>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-30-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Church Comm</i>		22d. LOCATION (City, town, or country) (State) <i>altavista na</i>	
23. FUNERAL DIRECTOR <i>Geo. H. Nelson 1348 N. Calhoun St</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. King</i>			

THE STATE
OF NEW YORK

1938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1938

DEPARTMENT OF HEALTH

STATE OF NEW YORK, COUNTY OF [illegible], CITY OF [illegible]

[Faint, mostly illegible text and lines forming a form structure, likely containing fields for patient information, cause of death, and examiner details.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

X

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13540											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bradshaw						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bradshaw					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reynolds Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last BRUCE GARFIELD Mac AULEY Jr.,						4. DATE OF DEATH Month Day Year December 24 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1911		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partnership				10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaner				11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Bruce G. Mac Auley, Sr.,						14. MOTHER'S MAIDEN NAME Mary A. Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)						16. SOCIAL SECURITY NO. 218-03-1248		17. INFORMANT Address Naomi E. Mac Auley Bradshaw Md.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital deformity of aortic valve and Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (b) 754.8 (a), stating the underlying cause last. (c) 754.8										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12/24/60		
EXAMINER'S NAME (Type) Charles S. Petty, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27, 1960		22c. NAME OF CEMETERY OR CREMATORY Salem Methodist				22d. LOCATION (City, town, or country) (State) Upper Falls Balto., Co., Md			
23. FUNERAL DIRECTOR Howard R. McKenna				ADDRESS Abingdon, Md.,				24a. REC'D BY REGISTRAR DEC 28 '60		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

1887

1887

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

U.S.A.

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

13568

13541

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		COUNTY lto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 Edmondson Ridge Road				d. STREET ADDRESS 25 Edmondson Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maude D. Marsh		4. DATE OF DEATH Month Day Year December 12, 1960 19					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1884		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Willis F. Overton		14. MOTHER'S MAIDEN NAME Samantha					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. John A. Harrison		Address 25 Edmondson Ridge Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Cancer of Stomach DUE TO (b) Egg in Esophagus DUE TO (c) C.P.D. of Stomach & Esophagus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 8 mo 6 mo 2 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 3, 1960 to Dec 12, 1960 ; that (I) (we) last saw the deceased alive on Dec 12, 1960 and that death occurred at 5 AM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. Earl W. King		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 12/60			
22c. PHYSICIAN'S NAME (Type) Dr. Earl W. King		22d. ADDRESS 11387th Parkway Bldg. 5					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/60		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Gickner		ADDRESS Balto 17 Md		25a. REC'D BY REGISTRAR DATE DEC 14 '60		25b. REGISTRAR'S SIGNATURE Charles E. Kraus	

2. SEX	3. COLOR OR RACE	7. MA. <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 18 YEARS OF AGE
		<input type="checkbox"/> DIVORCED <input type="checkbox"/>			

13569

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore SV01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS formerly of 2229 Orleans Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle T. Last MARTIN				4. DATE OF DEATH Month December Day 9 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/16/1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergk Johns Hopkins Hosp.				11. BIRTHPLACE (State or foreign country) Hungary			
12. CITIZEN OF WHAT COUNTRY? Hungary ✓							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-1627		17. INFORMANT Avondale, Md. Address Gertrude Tylor, niece, 4917 Russell Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Emphysema							INTERVAL BETWEEN ONSET AND DEATH 3 de. 15 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-27, 1960 , to 12-9, 1960 , that I last saw the deceased alive on 12-8, 1960 , and that death occurred at 3 de. M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE William K. Gallagher M.D. 6209 Frederick Road				12/9/60			
PHYSICIAN'S NAME (Type) William K. Gallagher M.D. Baltimore-28, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/60		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601 E. Madison St.				24a. REC'D BY REGISTRAR DATE DEC 14 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Kane	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

415

13570

13543

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY Balto		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 55 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		53		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		4. DATE OF DEATH Last DECEMBER 24		Month 1960		Day 19		
3. NAME OF DECEASED (Type or print) JOSEPH A. MAYGERS		First JOSEPH		Middle A.		Last MAYGERS		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 7, 1891		
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 69		IF UNDER 24 HRS. Days 69		Hours 69		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILERMAKER		10b. KIND OF BUSINESS OR INDUSTRY STANDARD OIL CO		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES MAYGERS		14. MOTHER'S MAIDEN NAME CATHERINE HOFFMAN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 215-07-1399		17. INFORMANT CLIN REC VAH BALTO 18 MD FT HOWARD DIVISION		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA; ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 30, 1960 , to Dec. 24, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 24, 1960 , and that death occurred at 4:05 a.m. from the causes and on the date stated above.								
22a. SIGNATURE LAWRENCE RUBIN		M.D. M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-24-60		
22c. PHYSICIAN'S NAME (Type) LAWRENCE RUBIN		22d. ADDRESS VAH BALTIMORE 18 MD-FT HOWARD DIVISION						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-27-60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave Dundalk 22 Md		25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

13548

13548

6.11

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13571

13544

1. NAME OF DECEASED (Type or Print) EMMA SMITH McMILLAN		2. DATE OF DEATH DEC. 6, 1960	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 096 Towson Convalescent Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4505 Roland Ave.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 2, 1876
9. AGE (In years last birthday) 84		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James H. Smith	
14. MOTHER'S MAIDEN NAME Frances R. Gibson		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT F. Howard Smith	
ADDRESS Homewood Apt.		18. CAUSE OF DEATH 420.0 CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE (B) a) ARTERIAL HYPERTENSION DUE TO b) AURICULAR FIBRILLATION (C) ARTERIOSCLEROSIS GENERALIZED WITH SENILE CALCIFICATION	
INTERVAL BETWEEN ONSET AND DEATH 12/4/60		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (the hospital) attended the deceased from APRox. 5 YEARS to 12-6-60 19 that (I) (we) saw the deceased alive on 12-5-60 19 and that in (my) (our) opinion death occurred at 11-30 A.M. from the causes and on the date stated above.	
23A. SIGNATURE W. Kennedy Walker ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23B. ADDRESS 3500 N. Calvert St.	
23C. DATE SIGNED 12/7/60		24. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE Dec. 8, 1960		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Bikesville Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 7 '60	
25B. NAME OF REGISTRAR Arthur E. Howard		25C. FUNERAL DIRECTOR John O. Mitchell & Sons Inc.	
ADDRESS			

CHIEF OF BUREAU

1961

CHIEF OF BUREAU
1961

CHIEF OF BUREAU
1961

CHIEF OF BUREAU
1961

CHIEF OF BUREAU
1961

CHIEF OF BUREAU
1961

13347

13347

MD

10-1

1

MD-1

MD-1

ROBERT ROBERT

WILLIAM A. BROWN

5 miles

COAST GUARD

NAVY AIRCRAFT

NAVY AIRCRAFT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13573

CERTIFICATE OF DEATH

Reg. Dist. No. 13546

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HEREFORD				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last MEDFORD				4. DATE OF DEATH Month 12 Day 26 Year 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17-1880	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME THOMAS MARINE				14. MOTHER'S MAIDEN NAME ELIZABETH CRAFT.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-0083		17. INFORMANT SON		Address MONKTON HEREFORD MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASULAR ACCIDENT 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC CARDIO VASULAR DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 11 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE C. Herbert Mueller Jr. M.D. Hereford - Packton P.O. Md 12/26/60 PHYSICIAN'S NAME (Type) C. HERBERT MUELLER Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) (State) Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

1

1

bp

M

CERTIFICATE OF DEATH

PLACE TO DATE		DATE OF DEATH	
MAY 19 1964		MAY 19 1964	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	
DECEASED'S NAME		DECEASED'S NAME	
JOHN J. JAMES		JOHN J. JAMES	
AGE		AGE	
68		68	
SEX		SEX	
M		M	
RACE		RACE	
W		W	
MARRIAGE		MARRIAGE	
M		M	
OCCUPATION		OCCUPATION	
RETIRED		RETIRED	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MAY 19 1964		MAY 19 1964	
PLACE TO DATE		DATE OF DEATH	
MAY 19 1964		MAY 19 1964	
COUNTY		COUNTY	
BALTIMORE		BALTIMORE	
DECEASED'S NAME		DECEASED'S NAME	
JOHN J. JAMES		JOHN J. JAMES	
AGE		AGE	
68		68	
SEX		SEX	
M		M	
RACE		RACE	
W		W	
MARRIAGE		MARRIAGE	
M		M	
OCCUPATION		OCCUPATION	
RETIRED		RETIRED	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MAY 19 1964		MAY 19 1964	

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
13574
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13547

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 29 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3318 McElderry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle N. Last MEINZINGER		4. DATE OF DEATH Month December Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1896
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64	IF UNDER 24 HRS. Days 64 Hours 64 Min. 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Hardware Store	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Meinzing	
14. MOTHER'S MAIDEN NAME Eva Goeller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 212-01-5148		17. INFORMANT Clin. Rec., VAH, Baltimore 18, Md. FORT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, RIGHT MIDDLE ARTERY DUE TO ARTERIOSCLEROSIS AND HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) XXXX		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from 11/23/60 to Dec. 22 , 1960, that X (we) lost saw the deceased alive on Dec. 22 , 1960, and that death occurred at 3:30 A. M. from the causes and on the date stated above.			
22a. SIGNATURE Fredrick S. Donaldson		22b. DATE SIGNED 12/22/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/24/60	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home 2601 Madison St.		25a. REC'D BY REGISTRAR DEC 27 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

10507

CENTRAL CHURCH

10507

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

SHIPPED TO: GORLICK FUNERAL HOME, 1700 Coney Island Ave., Brooklyn, N. Y.

1
13575
M
050
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13548

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN lb 9 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard d. STREET ADDRESS Quarters e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HERMAN Middle J. Last MEISEL, M. D.		4. DATE OF DEATH Month December 14 Day 19 Year 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 26, 1908	9. AGE (In years last birthday) yrs. 52	IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min. 15	IF UNDER 24 HRS. Hours 15 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Urologist- Surgeon		10b. KIND OF BUSINESS OR INDUSTRY Medicine - Hospital		11. BIRTHPLACE (State or foreign country) W. Hoboken, New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Abraham S. Meisel		14. MOTHER'S MAIDEN NAME Clara MN: Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. VAH, Baltimore 18, Md. Fort Howard Division		17. INFORMANT Clinical Records Address VAH, Baltimore 18, Md. Fort Howard Division		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 YEARS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December 5, 1960 to December 14, 1960 , that (I) (we) last saw the deceased alive on Dec. 14, 1960 , and that death occurred at 3:15 P. M. from the causes and on the date stated above.						
22a. SIGNATURE <i>Frederick S. Donaldson</i> M.D.		22b. DATE SIGNED 12/14/60		22c. PHYSICIAN'S NAME (Type) Dr. Frederick S. Donaldson		
22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12-15-60		23c. NAME OF CEMETERY OR CREMATORY Beth David		23d. LOCATION (City, town, or county) (State) Elmont, New York
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight, Inc</i> Wm. Cook-Blight, Inc.		24b. ADDRESS 6007 Hanford Rd		25a. REC'D BY REGISTRAR DATE DEC 16 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

10048

DECLARATION OF DEATH

10048

1

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	c. LENGTH OF STAY IN 1b 3 1/2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 8103 Smith Drive		d. STREET ADDRESS 1 8103 Smith Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James First Gipson Middle Last Middleton		4. DATE OF DEATH Month Dec. Day 12, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25. 1900
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Yellow Cab Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jess Middleton		14. MOTHER'S MAIDEN NAME Hester Middleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 218-18-4997	
17. INFORMANT Mrs. Hattie Middleton Same as 2 D		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420 y DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		DATE SIGNED 12/14/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-15-1960	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wells Funeral Home, Chestertown, Md.		24a. REC'D BY REGISTRAR DATE DEC 19 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13576
CERTIFICATE OF DEATH

13550

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 316 Magnolia Terrace		d. STREET ADDRESS 316 Magnolia Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle F. Last Milchling		4. DATE OF DEATH Month Dec. Day 24 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1891
9. AGE (In years lost, birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 5 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sprayer		10b. KIND OF BUSINESS OR INDUSTRY Automotive	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Milchling		14. MOTHER'S MAIDEN NAME Anna Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-7949	
17. INFORMANT Mrs. Anna M. Milchling		Address 316 Magnolia Terrace. 21	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 162X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/15 19 58 to 5-9 19 60 , that (I) (we) last saw the deceased alive on 5/9 19 60 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE St. Francis Medical Center		22b. DATE SIGNED DEC 28 '60	
22c. PHYSICIAN'S NAME (Type) St. Francis Medical Center		22d. ADDRESS 434 Boston Blvd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-1960	
23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		23d. LOCATION (City, town, or county) (State) Golden Ring Rd. Balto. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Larsen Funeral Home		25a. REC'D BY REGISTRAR DEC 28 '60	
ADDRESS 7401 Belair Rd.		25b. REGISTRAR'S SIGNATURE Arthur S. Kinner	

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

1937



13577

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>152 Arlington Village</u>	
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>Elizabeth</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1914</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>46</u> Days <u>15</u> Hours <u>X</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vaniels</u>		14. MOTHER'S MAIDEN NAME <u>Mary E.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>			
DUE TO (b) <u>Arteriosclerotic coronary thrombosis</u>			
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 30, 1960</u> to <u>Dec. 16, 1960</u> , that I last saw the deceased alive on <u>Dec. 16, 1960</u> , and that death occurred at <u>5:45a</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>12-16-60</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Wash Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Davidson Nam</u>		24a. REC'D BY REGISTRAR DATE <u>12-17-60</u>	
24b. REGISTRAR'S SIGNATURE <u>William Davidson Nam</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

DEATH OF A
FEMALE

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES A. BROWN		JANUARY 12, 1937		AT HOME	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JANUARY 1, 1872		NEW YORK		MAY 1, 1895	
FATHER'S NAME		MOTHER'S NAME		EDUCATION	
JOHN A. BROWN		MARY A. BROWN		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
FARMER		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		DATE OF BURIAL		PLACE OF BURIAL	
NONE		JANUARY 15, 1937		CATHOLIC CHURCH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER	
DECEASED'S ADDRESS		DECEASED'S PHONE		DECEASED'S OCCUPATION	
123 MAIN ST.		123		FARMER	
CITY		COUNTY		STATE	
NEW YORK		NEW YORK		NEW YORK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13444 CERTIFICATE OF DEATH 13552											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RELAY</u>				c. LENGTH OF STAY IN 1b <u>20 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BALTIMORE</u>				d. STREET ADDRESS <u>13130 BERKSHIRE RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RELAY Hill Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ALEXANDER</u> Middle <u>MITCHELL, Jr</u>						4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>19 60</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 28, 1899</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B&O RR. RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALEXANDER MITCHELL SR.</u>						14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH VECHIO</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>705 05 0067</u>		17. INFORMANT <u>3130 Berhshire Road Mrs Mae Roth Mitchell</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL Thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO <u>PARKINSON'S DISEASE</u> (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 1/2 yrs</u> <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that <u>11</u> (this hospital) attended the deceased from <u>April 15, 19 57</u> to <u>Dec 25, 19 60</u> , that (I) (we) last saw the deceased alive on <u>Dec 25, 19 60</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Lewis P. Gundry</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-25-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>LEWIS P. GUNDRY</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC. BALTO. MD.</u> ADDRESS						25. REC'D BY REGISTRAR <u>DEC 28 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

1934

1934

APR 28 1934

GEORGE B. BARRIS

13130 Pennsylvania Road

Washington, D.C.

1

1228750 LONDON PARK GENESEE BATHING MARLBOROUGH

HENRY GARDNER & SONS INC. BALTO. MD.

CERTIFICATE OF DEATH

13553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Haven Home</u>		d. STREET ADDRESS <u>St Paul St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harvey Mitchell</u> First Middle Last		4. DATE OF DEATH <u>Dec. 23</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
13. FATHER'S NAME <u>Wm. F. Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Martha L. Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212 10 3045</u>	
17. INFORMANT <u>Wm. Blundell, Arlington, Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>associated w A.S.C.V.D and</u> DUE TO (c) <u>chronic cordine failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While o. m. p. m. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-9</u> , 19 <u>60</u> , to <u>12-23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-23-60</u> , 19 <u>60</u> , and that death occurred at <u>12:57</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank J. Macak Jr.</u> M.D. <u>1613 Forest Park Ave</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11-23-60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pinecrest Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Herndon, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Green Funeral Home, Herndon</u>		24a. REC'D BY REGISTRAR <u>DEC 27 50</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

By Macak - Don Co - 28

TO HOSPITAL BY ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

13579

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13554

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Professional House				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
3. NAME OF DECEASED (Type or print) First DAVID Middle H. Last MORSTEIN				4. DATE OF DEATH Month DEC. Day 11 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 20, 1900	
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Morstein				14. MOTHER'S MAIDEN NAME Rebecca Barshop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. :		17. INFORMANT Stanley Morstein-- Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease 411X DUE TO aortic stenosis sinusitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/16 to 12/11 , 19 60 , that (I) (we) last saw the deceased alive on 11/16/60 , 19 60 , and that death occurred at 12/11 M, from the causes and on the date stated above.							
22a. SIGNATURE Charles B. King MD				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/17/60	
22c. PHYSICIAN'S NAME (Type) Charles B. King				22d. ADDRESS 2320 Entwistle Place			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/14/60		23c. NAME OF CEMETERY OR CREMATORY Lakeside Memorial Park		23d. LOCATION (City, town, or county) (State) Miami, Florida	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Bernstein & Son, Inc.				ADDRESS 6010 Reisterstown Rd.		25a. REC'D BY REGISTRAR DEC 15 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1955

STATE OF ALABAMA DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1955

Blank certificate form with fields for:

- NAME
- AGE
- SEX
- RACE
- DATE OF BIRTH
- DATE OF DEATH
- PLACE OF DEATH
- Cause of Death
- Signature
- Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13580

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13555

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 15 hrs. 15 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 15 d. STREET ADDRESS 2507 Oakley Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAWRENCE E. MUMAW		4. DATE OF DEATH Month December Day 30 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Cafeteria		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			
13. FATHER'S NAME Paul Mumaw		14. MOTHER'S MAIDEN NAME Ella Lewis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW-1		16. SOCIAL SECURITY NO. 215-09-9023		17. INFORMANT Clinical Records VAH Baltimore 18 Md-FORT HOWARD DIVISION			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 792X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4 weeks				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dec. 29 1960			
20f. (City or town) Dec. 30 1960		20g. (County) 3A15		20h. (State) to Dec. 30 1960			
21. I certify that (X) (this hospital) attended the deceased from Dec. 29 1960 to Dec. 30 1960 , that (Y) (we) last saw the deceased alive on Dec. 30 1960 , and that death occurred at 3A15 M, from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson		22b. DATE SIGNED 12/30/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.			
22d. ADDRESS VAH Fort Howard, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
23d. LOCATION (City, town or county) Baltimore		23e. (State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace F. Burgee		24a. ADDRESS 3631 Falls Road Baltimore, Maryland		25a. REC'D BY REGISTRAR DATE JAN 3 '61			
25b. REGISTRAR'S SIGNATURE Arthur J. H...							

10000

10000

TO THE HONORABLE SECRETARY OF THE ARMY
WASHINGTON, D. C.
SIR:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter mentioned therein.
The same has been referred to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. H. HARRIS
Major General, U. S. Army

THE HONORABLE SECRETARY OF THE ARMY
WASHINGTON, D. C.
SIR:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter mentioned therein.
The same has been referred to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. H. HARRIS
Major General, U. S. Army

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
#

13581

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13556

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN lb 70 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (14) d. STREET ADDRESS 3134 Acton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle R. Last O'BRIEN				4. DATE OF DEATH Month December Day 13 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 4, 1889	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min. 71			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor				10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas O'Brien				14. MOTHER'S MAIDEN NAME Mary Harrington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 215-32-9887		17. INFORMANT Clinical Records Address VAH, Baltimore 18, Maryland, Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. HYPERTROPHY AND DILATATION OF HEART WITH VALVULAR INSUFFICIENCY CARDIAC DECOMPENSATION INTERVAL BETWEEN ONSET AND DEATH 4 DAYS UNKNOWN 1 YEAR							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from October 4, 1960 to December 13, 1960 , that (X) (we) last saw the deceased alive on Dec. 13, 1960 , and that death occurred at 11:15 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22b. DATE SIGNED 12/14/60 22d. ADDRESS VAH, Baltimore 18, Md. Fort Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/60		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Funeral Home, Baltimore 14, Md.				25a. REC'D BY REGISTRAR DATE DEC 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

BP

MAINTENANCE DEPARTMENT HEALTH
CERTIFICATE OF DEATH

1938

Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Report		Time of Report		Place of Report	
Signature of Medical Officer		Signature of Health Officer		Signature of Sanitary Officer	
Signature of Nurse		Signature of Dispenser		Signature of Pharmacist	
Signature of Apothecary		Signature of Druggist		Signature of Chemist	
Signature of Analyst		Signature of Inspector		Signature of Examiner	
Signature of Assessor		Signature of Collector		Signature of Treasurer	
Signature of Auditor		Signature of Clerk		Signature of Stenographer	
Signature of Messenger		Signature of Porter		Signature of Janitor	
Signature of Cook		Signature of Baker		Signature of Butcher	
Signature of Grocer		Signature of Fishmonger		Signature of Fruit Vendor	
Signature of Vegetable Vendor		Signature of Flower Vendor		Signature of Toy Vendor	
Signature of Book Vendor		Signature of Stationery Vendor		Signature of Clothing Vendor	
Signature of Hat Vendor		Signature of Shoe Vendor		Signature of Jewelry Vendor	
Signature of Watch Vendor		Signature of Optical Vendor		Signature of Musical Vendor	
Signature of Sporting Vendor		Signature of Travel Vendor		Signature of Insurance Vendor	
Signature of Real Estate Vendor		Signature of Legal Vendor		Signature of Medical Vendor	
Signature of Veterinary Vendor		Signature of Agricultural Vendor		Signature of Manufacturing Vendor	
Signature of Mining Vendor		Signature of Transportation Vendor		Signature of Communication Vendor	
Signature of Public Utility Vendor		Signature of Government Vendor		Signature of Religious Vendor	
Signature of Educational Vendor		Signature of Entertainment Vendor		Signature of Miscellaneous Vendor	

1
Page 4
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13582
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14575

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 1 yr. 11 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Offutt		4. DATE OF DEATH Month 12 Day 12 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/58
9. AGE (In years lost birthday) 2 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Frederick Offutt, Jr.		14. MOTHER'S MAIDEN NAME Virginia Frances DiMaggio	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 344X IMMEDIATE CAUSE (a) Extensive hydrocephalus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-15-60 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 4:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. W. Rieckert, Pathologist		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Pet. W. Rieckert		22d. ADDRESS 4307 Mainfield Ave, Bldg 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-15-60	
23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
25a. REC'D BY REGISTRAR FEB 6 '61			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13583
CERTIFICATE OF DEATH
13557

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills,		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Mary Last O'NEILL		4. DATE OF DEATH Month 12 Day 20 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/52
9. AGE (In years last birthday) 8 yrs.		10. IF UNDER 1 YEAR Months 8 Days 12 Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - -		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald Vincent O'Neill		14. MOTHER'S MAIDEN NAME Roberts, Theresa Anne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Rosewood records		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gorgoxylism complicated by 289.0 DUE TO bilateral otitis media Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/22/54 to 12/20/60 , that (I) (we) last saw the deceased alive on 12/20/60 , and that death occurred at 3:55 p.m. from the causes and on the date stated above.			
22a. SIGNATURE H W Beekat Pathologist M.D.		22b. DATE SIGNED 12-21-60	
22c. PHYSICIAN'S NAME (Type) Peter W Rieckert		22d. ADDRESS 4307 Mainfield Ave, Balto 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 22 1960	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City, town, or county) (State) Monte Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Stalls		25a. REGISTERED BY REGISTRAR DEC 23 1960	
25b. REGISTRAR'S SIGNATURE William S. Travis		25c. ADDRESS 254 CARROLL ST NW	

ph. lat. 20° 00' N. 100° 00' W.
val. 1000 fathoms

x

W. H. Wood
R. H. Wood

5050

1000 fathoms
1000 fathoms

13584

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>Alexandria VA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova.</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG Home</u>				d. STREET ADDRESS <u>Bay City</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>M.</u> Last <u>PANGBORN</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 3. 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Winfield Laddoris</u>				14. MOTHER'S MAIDEN NAME <u>Anna Laura</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Records</u>				Address <u>6811 Campfield Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Arterio - Sclerotic Heart Disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(2) Broncho - Pneumonia</u> DUE TO <u>—</u> (c) <u>(3) Bronchial Asthma</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>3 days</u> <u>6 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April</u> <u>1960</u> to <u>Dec 29</u> <u>1960</u> , that I last saw the deceased alive on <u>Dec 28</u> <u>1960</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u>				ADDRESS (Street, city or town, state) <u>4108 Liberty Hts. Balto - 12-55-6</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>				DATE SIGNED <u>4108 Liberty Hts Balto - 7-mid</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-31-60</u>		<u>NAT. MEM. PARK</u>		<u>FALLS CHURCH VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Stehman</u>				ADDRESS <u>6067 Hay Rd</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>JAN 4 '61</u>				<u>Arthur L. Thomas</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13584

UNITED STATES DEPARTMENT OF AGRICULTURE

CERTIFICATE OF ANALYSIS

13584

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
13585													
13559													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1910 Mountain Ave.</u>						d. STREET ADDRESS <u>1910 Mountain Ave.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last						4. DATE OF DEATH Month Day Year							
<u>Jean G. Payne</u>						<u>12 7 19 60</u>							
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-25-1926</u>		9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days			
										IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Claude O. Graves</u>						14. MOTHER'S MAIDEN NAME <u>Minnie H. Miller</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charles Payne</u> Address <u>same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous & hypostatic Pneumonia</u> <u>153.9</u> DUE TO (b) <u>Carcinoma of large & small</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>intestines</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Jun 2-1960</u> <u>to Dec 7-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6-2-1960</u> to <u>12-7-1960</u> , that (I) (we) last saw the deceased alive on <u>12-6-1960</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Lee H Fargo MD</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>LEE K FARGO MD</u>						22d. ADDRESS <u>8155 Loch Raven Blvd</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>						ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>DEC 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

13586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>			c. LENGTH OF STAY IN 1b <u>70 yrs.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Vernon Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry G. Pearce</u>			4. DATE OF DEATH Month Day Year <u>December 7 1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 5, 1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Joseph W. Pearce</u>			14. MOTHER'S MAIDEN NAME <u>Mary Frances Lytle</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-24-4868</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arterio-Sclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>Dec. 5</u> , 19 <u>60</u> , to <u>Dec. 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 7</u> , 19 <u>60</u> , and that death occurred at <u>8:20 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A. M. France</u> M.D.			ADDRESS (Street, city or town, state) <u>FARRINGTON, Md.</u> DATE SIGNED <u>12/8/60</u>		
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 10, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>	22d. LOCATION (City, town, or county) <u>White Hall, Md.</u> (State) _____		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom, Pa.</u> ADDRESS _____			24a. REC'D BY REGISTRAR DATE <u>DEC 12 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13586

CERTIFICATE OF DEATH

13586

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a certificate of death, mentioning names and dates.]

1
M
X
I
G
BP

13587

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13561

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b <u>54 Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>517 Eastern Ave. (21)</u>				d. STREET ADDRESS <u>1517 Eastern Ave. (21)</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY PERSIA</u>				4. DATE OF DEATH Month Day Year <u>DEC. 13 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-81</u>	
9. AGE (In years lost birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>JOSEPH DE ANGELIS</u>				14. MOTHER'S MAIDEN NAME <u>MARYANN ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>ANN BETKEY (SAME AS ABOVE)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Arteriosclerotic Cardio-Vascular disease 2 yrs</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1 1960</u> to <u>Dec 13 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 13 1960</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>M. Burroughs</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. Burroughs</u>				22d. ADDRESS <u>Balto 6 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-17-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO, CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly 418 Eastern Blvd. (21)</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 19 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

13588

CERTIFICATE OF DEATH

13562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5mth20dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Pilert Last Pilert		4. DATE OF DEATH Month December Day 12 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, Unknown, 1873?
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months 9 Days 24	IF UNDER 24 HRS. Hours 24 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown David Powers		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 434.1 (b) AUricular Fibrillation DUE TO (c) Decompensated heart failure		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1960 , to Dec. 12, 1960 , that I last saw the deceased alive on Dec. 12, 1960 , and that death occurred at 8:15 a. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-12-60	
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-60	
22c. NAME OF CEMETERY OR CREMATORY Louder Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Fred. A. Cole		ADDRESS 1913 W. Baltimore St.	
24a. REC'D BY REGISTRAR DEC 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

13589

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13563

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 75 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEROY Middle A. Last PLUMHOFF		4. DATE OF DEATH Month December Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1925
9. AGE (In years lost birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman		10b. KIND OF BUSINESS OR INDUSTRY Tire Recapping	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Plumhoff		14. MOTHER'S MAIDEN NAME Louise Didman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-11 212-20-3896	
17. INFORMANT Clinical Records		Address VAH, Baltimore, Md. - FORT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 METASTATIC CARCINOMA-PRIMARY SITE UNDETERMINED DUE TO (b) 18 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 18 months DUE TO (c) 18 months		INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 19 1960 to Dec. 3 1960 that (X) (we) lost saw the deceased alive on Dec. 3 1960, and that death occurred at 4:10 A. M. from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert M.D.		22b. DATE SIGNED Dec. 3, 1960	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, Baltimore, 18, Md. Ft. Howard Div.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOMES		25a. REC'D BY REGISTRAR DATE DEC 6 '60	
ADDRESS 2112 Dundalk Ave. Baltimore 22, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(15 (4)
9/59

15503

15503

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VETERANS AFFAIRS
OFFICE OF THE ASSISTANT SECRETARY
WASHINGTON, D. C. 20460

Form 10-108 (Rev. 1-1-60)

1. NAME (Last, first, middle initial)
2. SERVICE NO.
3. DATE OF BIRTH (Month, day, year)
4. PLACE OF BIRTH (City, State, Country)
5. GRADE OR RATE
6. DATE OF ENTRY INTO SERVICE (Month, day, year)
7. DATE OF SEPARATION FROM SERVICE (Month, day, year)
8. REASON FOR SEPARATION (Check one)
a. Discharged
b. Retired
c. Died
d. Other (Specify)
9. DATE OF DEATH (Month, day, year)
10. PLACE OF DEATH (City, State, Country)
11. CAUSE OF DEATH (Specify)
12. DATE OF INTERVIEW (Month, day, year)
13. NAME OF INTERVIEWER (Last, first, middle initial)
14. SIGNATURE OF INTERVIEWER
15. TITLE OF INTERVIEWER
16. DATE OF REVIEW (Month, day, year)
17. NAME OF REVIEWER (Last, first, middle initial)
18. SIGNATURE OF REVIEWER
19. TITLE OF REVIEWER
20. DATE OF APPROVAL (Month, day, year)
21. NAME OF APPROVER (Last, first, middle initial)
22. SIGNATURE OF APPROVER
23. TITLE OF APPROVER
24. DATE OF FINAL REVIEW (Month, day, year)
25. NAME OF FINAL REVIEWER (Last, first, middle initial)
26. SIGNATURE OF FINAL REVIEWER
27. TITLE OF FINAL REVIEWER

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13590

CERTIFICATE OF DEATH

13564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1 Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Agnes Mearns Wamers Home</u>		d. STREET ADDRESS <u>219 W. Lafayette Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miss Mary G. Parter</u>		4. DATE OF DEATH Month Day Year <u>Dec. 11 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>7 11</u>	11. IF UNDER 24 HRS. Hours Min. <u>7 11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John M. Parter</u>		14. MOTHER'S MAIDEN NAME <u>Abigail Ruskell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Dan E. Hammeton</u>		Address <u>615 Chestnut A.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>arterio-sclerotic Cerebral Vascular Disease</u> DUE TO (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 26, 1960</u> to <u>December 11, 1960</u> ; that I lost sight of the deceased alive on <u>December 11, 1960</u> , and that death occurred at <u>3:39 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland Edward Day</u>		ADDRESS (Street, city or town, state) <u>4-E-33d St Baltimore Md</u>	
DATE SIGNED <u>Dec 11, 1960</u>			
PHYSICIAN'S NAME (Type) <u>NEWLAND EDWARD DAY M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-14-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>			

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "John" and "Mary" are faintly visible.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

M

1

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
13591 CERTIFICATE OF DEATH 13565									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3528 BARTON OAKS RD</u>					d. STREET ADDRESS <u>13528 BARTON OAKS RD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>1999C POTTS</u>					4. DATE OF DEATH Month Day Year <u>12 - 30 - 1960</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 15, 1883</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL STORE</u>		11. BIRTHPLACE (State or foreign country) <u>TENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>EPHRAIM MORDECIA</u>					14. MOTHER'S MAIDEN NAME <u>BATH SHEBA</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>JULIA B. F. POTTS - 3528 BARTON OAKS RD</u>				Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF PROSTATE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>3mo</u> <u>5 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>5-10</u> , 19 <u>60</u> , to <u>12-30</u> , 19 <u>60</u> , that (1) (we) last saw the deceased alive on <u>12-30</u> , 19 <u>60</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Martin A. Robbins</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-31-60</u>		
22c. PHYSICIAN'S NAME (Type) <u>MARTIN A. ROBBINS</u>					22d. ADDRESS <u>2109 Southcliff Dr</u> (9)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1-1-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc - 2100 Eutan Pl.</u>					25a. REC'D BY REGISTRAR <u>JAN 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		

1258

101 101 101 101

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13566

13592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House In The Pines 16 Fusting Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18 d. STREET ADDRESS #211, Greenway Apts e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		4. DATE OF DEATH Month December Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1883
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Municipal Bldg		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Price		14. MOTHER'S MAIDEN NAME Florence Herman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-16-7560	
17. INFORMANT Mrs. Rosa I. Price, #211, Greenway Apts, Zone 18		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) Arteriosclerosis Cordis-Vasculis Cerebralis INTERVAL BETWEEN ONSET AND DEATH 1 day 8 yr. 10 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-24-1960 to 12-20-1960 , that I last saw the deceased alive on 12-20-1960 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William K. Gallagher		ADDRESS (Street, city or town, state) 6229 Frederick Ave. Baltimore, Md.	
DATE SIGNED 12-22-60			
PHYSICIAN'S NAME (Type) William K. Gallagher		Baltimore - 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-23-60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DEC 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

SECRET



SECRET

SECRET

SECRET
U.S. GOVERNMENT
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C.

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET



SECRET

SECRET

SECRET

SECRET

SECRET

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13593 CERTIFICATE OF DEATH 13567

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b X Cockeysville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Martin Last Rafferty		4. DATE OF DEATH Month 12 Day 15 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-26-1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 12 Days 15 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner, & mang		10b. KIND OF BUSINESS OR INDUSTRY Transfer, Express	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Rafferty		14. MOTHER'S MAIDEN NAME Ellen Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-8422	
17. INFORMANT Miss Nellie T. Nevin		Address Cockeysville York Rd. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BACTERIOLOGIC CEREBRO VASCULAR DISEASE 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 1959 to DEC 15 1960 , that (I) (we) last saw the deceased alive on DEC 13 1960 , and that death occurred at 7:55 M, from the causes and on the date stated above.			
22a. SIGNATURE William A. Pillsbury		22b. DATE SIGNED 12-16-60	
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury		22d. ADDRESS Timonium, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 12-17-60	
23c. NAME OF CEMETERY OR CREMATORY St. Josephs		23d. LOCATION (City, town, or county) (State) Texas Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service York Rd Towson 4		25a. REC'D BY REGISTRAR DEC 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Evans			

13587

CERTIFICATE OF DEATH

13587

State of New York
County of New York
City of New York
I, the undersigned, being a duly qualified medical officer of health for the City and County of New York, do hereby certify that
On the _____ day of _____, 19____, at _____, New York
Died _____
Cause of death _____
Age _____
Sex _____
Color _____
Married _____
Occupation _____
Usual residence _____
Place of birth _____
Signature of Medical Officer of Health _____
Signature of Registrar _____
No. _____

Witness my hand and the seal of the City and County of New York, this _____ day of _____, 19____.
Mayor of the City and County of New York _____
Recorder of the City and County of New York _____
City and County of New York
New York, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13594

CERTIFICATE OF DEATH

Reg. Dist. No.

13568

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Clyde Last Randle				4. DATE OF DEATH Month December Day 7 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-1877 1879	
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months 12 Days X Hours 2		IF UNDER 24 HRS. Months 12 Days X Hours 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown electrician				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Unknown Joseph E. Randle				14. MOTHER'S MAIDEN NAME Unknown Margaret Ann Winters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SPRING GROVE STATE HOSPITAL				20g. (County) Harford		20h. (State) Maryland	
21. I certify that I attended the deceased from Nov. 10, 1960 to December 7, 1960 , that I last saw the deceased alive on December 7, 1960 , and that death occurred at 5:35 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jose R. Arizaga				DATE SIGNED SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Jose R. Arizaga, M.D.				LOCATION (City, town, or county) (State) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-60		22c. NAME OF CEMETERY OR CREMATORY Greenwood Ridge		22d. LOCATION (City, town, or county) (State) Catonsville 28 md	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Marshall				ADDRESS Pike 8 md		24a. REC'D BY REGISTRAR DEC 9 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: ALICE M. BROWN</p>		<p>2. Sex: F</p>	
<p>3. Age: 65</p>		<p>4. Date of birth: 1885</p>	
<p>5. Place of birth: MASSACHUSETTS</p>		<p>6. Date of death: 1950</p>	
<p>7. Cause of death: HEART DISEASE</p>		<p>8. Place of death: HOSPITAL</p>	
<p>9. Signature of physician: DR. J. H. SMITH</p>		<p>10. Signature of registrar: JOHN D. BROWN</p>	
<p>11. Date of filing: 1950</p>		<p>12. File number: 100-100000</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 BUREAU OF VITAL RECORDS
 100-100000

CERTIFICATE OF DEATH

Reg. Dist. No.

13569

13595

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Same Maryland</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shawon Road</u>				e. STREET ADDRESS <u>15902 Smith Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Anna Reilly</u>				4. DATE OF DEATH Month Day Year <u>Dec 18 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Joseph Caffary</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Helen Brennan, Shawon Road, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>56</u> , to <u>Dec 18</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 17</u> 19 <u>60</u> , and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D. <u>1620 Rustentown Road</u> PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u> <u>Pikesville 8, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, county) (State)	
<u>Burial</u>		<u>Dec 32 1960</u>		<u>St. Josephs</u>		<u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Surgee Funeral Home 3031 Falls Road</u> <u>Prince F. Surgee</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hester</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

40-232

1
Page 4
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13596

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 1-5-61

13570

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ARMACOST NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1 5008 BOXHILL LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NANNIE Middle D. Last RETZER		4. DATE OF DEATH Month 12 Day 22 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 3-31-1960
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN T. RIDGELY		14. MOTHER'S MAIDEN NAME SARAH JERVIS HOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT DR. ROBERT RETZER		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERY THROMBOSIS 332X DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO SENILITY (c) SENILITY		INTERVAL BETWEEN ONSET AND DEATH 4 mo 12 yrs 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 19 19 60 to Dec 22 19 60 that (I) (we) last saw the deceased alive on Dec 21 19 60 and that death occurred on Dec 22 19 60 from the causes and on the date stated above.			
22a. SIGNATURE A.S. Chalfant		22b. DATE SIGNED Dec 22 60	
22c. PHYSICIAN'S NAME (Type) A.S. CHALFANT		22d. ADDRESS 6810 YORK RD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-28-60	
23c. NAME OF CEMETERY OR CREMATORY HOOD PRIVATE BURIAL GROUND		23d. LOCATION (City, town, or county) (State) Howard Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS Co.		25a. REC'D BY REGISTRAR JAN 8 '61	
ADDRESS 4905 YORK RD.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

13386

CERTIFICATE OF MARRIAGE

13386

DATE

WM

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13597

CERTIFICATE OF DEATH

Reg. Dist. No.

13571

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr9mth2ldys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Janette Middle Lennon Last Reynolds		4. DATE OF DEATH Month December Day 28 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1881
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Myland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic popliteal aneurysm with rupture & gangrene left leg DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 9, 1960 , to Dec. 28, 1960 , that I last saw the deceased alive on Dec. 28, 1960 , and that death occurred at 3:20 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslor		DATE SIGNED SPRING GROVE STATE HOSPITAL 12-28-60	
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/60	22c. NAME OF CEMETERY OR CREMATORY St. Augustine's	22d. LOCATION (City, town, or county) (State) Elkridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.4101 Edmondson Ave.		24a. REC'D BY REGISTRAR JAN 3 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 13

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13598

CERTIFICATE OF DEATH

Reg. Dist. No.

13572

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convul.Home				d. STREET ADDRESS 7920 Ruxway Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ERNEST G. RICHARDSON				4. DATE OF DEATH Dec. 29, 1960 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1879		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Loren Richardson				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Henrietta (Last name unknown)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. L. Brent Wood, 7920 Ruxway Rd. Ruxton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) Parkinson's Disease INTERVAL BETWEEN ONSET AND DEATH 5 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1955 , to Dec 29, 1960 , that I last saw the deceased alive on Dec 24, 1960 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Luthersville, Md DATE SIGNED 12/29/60							
ACTUAL SIGNATURE George T. Gilmore M.D.							
PHYSICIAN'S NAME (Type) GEORGE T GILMORE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/1/61		22c. NAME OF CEMETERY OR CREMATORY Mexico Cemetery		22d. LOCATION (City, town, or county) (State) Mexico, New York	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Cook-Towson, Inc. York Rd. Towson, Md.				24a. REC'D BY REGISTRAR DATE JAN 3 '61		24b. REGISTRAR'S SIGNATURE C. L. K.	

1
M
014
1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13599
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
13573

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Katherine Middle Bell Last Richardson		4. DATE OF DEATH Month December Day 22 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1922
9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk - prac. nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Vincent Reagan		14. MOTHER'S MAIDEN NAME Mary Ann Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes-WACS		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1942-45	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 715X IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Decubitus ulcers DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 22 19 60 to Dec. 22 1960, that (I) (we) last saw the deceased alive on Dec. 22 19 60, and that death occurred at 8:30 A. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 12-27-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tackner & Sons		25a. REC'D BY REGISTRAR DEC 28 '60	
ADDRESS Baltimore Md		25b. REGISTRAR'S SIGNATURE William S. Thomas	

AMERICAN STATE DEPARTMENT OF HEALTH

1990

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13600

CERTIFICATE OF DEATH

Reg. Dist. No.

13574

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3mth13dys</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				3. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1960</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Gertrude</u> Last <u>Rigby</u>				5. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		11. IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Elijah West</u>				14. MOTHER'S MAIDEN NAME <u>Lucinad WARNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>				20f. (City or town) (County) (State) <u>—</u>			
21. I certify that I attended the deceased from <u>Sept. 6, 1960</u> , to <u>Dec. 19, 1960</u> , that I last saw the deceased alive on <u>Dec. 19, 1960</u> , and that death occurred at <u>2:40p M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 12-19-60</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec. 21-1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Truman Schuch</u>				24a. REC'D BY REGISTRAR <u>—</u>			
24b. REGISTRAR'S SIGNATURE <u>—</u>				DATE <u>DEC 21 '60</u>			

MEDICAL CERTIFICATION

3512 Frederick Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13601

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. JOSEPH'S NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle HENRY Last RILEY		4. DATE OF DEATH Month DEC. Day 13 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DEC. 16, 1902
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WRITER		10b. KIND OF BUSINESS OR INDUSTRY NEWS-PAPER	11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George M. Riley	
14. MOTHER'S MAIDEN NAME Mary Murphy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. MacLeod-Ballenger, 14 Westminister	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left bundle branch block of heart DUE TO Fluid in left chest DUE TO Bronchiogenic Carcinoma DUE TO --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema (Edema of thighs & legs)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 8 weeks 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 12, 1960 to Dec 13, 1960 , that I last saw the deceased alive on 12/13 , 1960, and that death occurred at 11:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L.J. Volenick M.D.		ADDRESS (Street, city or town, state) 4710 Liberty Hts. Apt. A-3 Balto. DATE SIGNED 12/15/60	
PHYSICIAN'S NAME (Type) L.J. VOLENICK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-17-60	22c. NAME OF CEMETERY OR CREMATORY Catholic Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE John C. Conway, Jr. - Catonsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 19 1960	
24b. REGISTRAR'S SIGNATURE Carlton S. Kneale			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15232

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

13801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13602

13576

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 28 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore (2) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 200 N. Aisquith Street d. STREET ADDRESS 3801-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES H. ROBINSON		4. DATE OF DEATH Month December Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1908
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 28 Hours 12 Min. 30	IF UNDER 24 HRS. Hours 12 Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (County & State, or foreign country) Norwood, N. Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Sam Robinson	
14. MOTHER'S MAIDEN NAME Rebecca Robinson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 241-18-3771		17. INFORMANT Clinical Records VAH, Baltimore 18, Maryland, Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION 420.1 EDEMA OF THE LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. LOBAR PNEUMONIA (b) UNKNOWN (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 7 WEEKS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m. 12:30		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from November 29, 1960 to December 27, 1960 , that (X) (we) last saw the deceased alive on Dec. 27, 1960 , and that death occurred at A.M. from the causes and on the date stated above.			
22a. SIGNATURE FREDERICK S. DONALDSON		22b. DATE 12/27/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, Baltimore 18, Md., Fort Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George Queen		25a. REC'D BY REGISTRAR JAN 3 61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS W. Lafayette Baltimore 16, Maryland	

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

1819

13603

CERTIFICATE OF DEATH

13577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>623 Hillen Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William H. St. Clair</u>				4. DATE OF DEATH Month Day Year <u>Dec. 26, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1896</u>	9. AGE (In years last birthday) yrs. <u>64</u>	10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Oil Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Kelly St. Clair</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Marquardt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World I</u>		16. SOCIAL SECURITY NO. <u>212-09-0101</u>		INFORMANT <u>Mrs. William H. St. Clair-623 Hillen Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> (c) <u>General arteriosclerosis and hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 yrs.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Family tendency to hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 20, 1960</u> to <u>Dec. 26, 1960</u> , that I last saw the deceased alive on <u>Dec. 20, 1960</u> , and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Wright</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Medical Arts Bldg., Baltimore 1, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Robert B. Wright</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Long & Sons</u>		ADDRESS <u>Balto 17, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1977

CERTIFICATE OF DEATH

1977

CHIEF OF POLICE

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 2 HOURS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1385 WOODYEAR STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ELLWOOD		Middle F.		Last SAVAGE		4. DATE OF DEATH Month DECEMBER	
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 16, 1924		9. AGE (In years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESS OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11		17. INFORMANT CLIN REC-VAH BALTO 18 Md-FT HOWARD DIVISION					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1. UREMIA DUE TO #2 2. CHRONIC GLOMERULONEPHRITIS 3. HYPERTROPHY AND DILATATION OF THE HEART DUE TO #2 4. EDEMA, LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (a) (this hospital) attended the deceased from Dec. 16, 1960 to Dec. 16, 1960 , that (b) (we) last saw the deceased alive on Dec. 16, 1960 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Charles E. Rowan CHARLES E. ROWAN				M.D. M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-17-60	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS VAH BALTIMORE 18 MD-FT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/21/60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				ADDRESS 1808-10 N Monroe St Baltimore 17 Md		25a. REC'D BY REGISTRAR DEC 19 '60		25b. REGISTRAR'S SIGNATURE Charles E. Rowan	

STATE OF NEW YORK

1894

STATE

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13605				CERTIFICATE OF DEATH				13579			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY		BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE		b. COUNTY	
		MARYLAND		PARKVILLE				MD		Balt	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		8016 Ridgely OAK Rd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		PARKVILLE		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		Mrs CLARA Luise SCHILDT		5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
				Female		White				OCT. 17, 1874	
										9. AGE (In years last birthday) yrs. Months Days Hours Min.	
										86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		GERMANY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
										Germany	
13. FATHER'S NAME		FERDINAND Dahms		14. MOTHER'S MAIDEN NAME		Wilhelmine Jahnke					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMATION							
		220-22-448		MR HANS SCHILDT							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										6 days	
3822X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										4 years	
(b) Arteriosclerosis											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
										20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 1951 to Dec. 28, 1960, that (I) (we) last saw the deceased alive on Dec. 23, 1960, and that death occurred at 3 AM, from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
R Donald Jandorf											
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
R Donald Jandorf										6077 Harford Rd, Balto. 14, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF	
BURIAL										12-20-60	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)	
Moreland Mem. Park										BALTIMORE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE										25. REC'D BY REGISTRAR	
Leonard J. Ruck										5305 Harford Rd	
25a. ADDRESS										25b. REGISTRAR'S SIGNATURE	
5305 Harford Rd										DEC 29 '60	

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

13003

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13580

13606

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3815 Brownhill Road</u>		d. STREET ADDRESS <u>3815 Brownhill Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Lee</u> Last <u>Schmidt</u>		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1921</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond A. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Florence E. Bilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-24-3712</u>	
17. INFORMANT <u>Mr. William F. Schmidt</u>		Address <u>3815 Brownhill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>147X</u> IMMEDIATE CAUSE (a) <u>Carcinoma, squamous cell, of hypopharynx</u> DUE TO <u>15 mos +</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis, Larynx</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 13, 1960</u> , to <u>Dec 13, 1960</u> , that I last saw the deceased alive on <u>Dec 13, 1960</u> , and that death occurred at <u>4:50 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Wm Carl Ebeling</u> M.D. <u>410 Med. Arts Bldg Balto Md 12-15-60</u>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <u>Wm. Carl Ebeling, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons</u>		ADDRESS <u>Balto 17 Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

15580

CERTIFICATE OF DEATH

15105

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be organized into sections, possibly for personal information, cause of death, and medical history.]

1
13607
50
1
2
BPO
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland					c. LENGTH OF STAY IN 1b 21 days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LOUIS					4. DATE OF DEATH Month December Day 26 Year 19 60				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH May 10, 1897				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler-Watchmaker					11. BIRTHPLACE (County & State, or foreign country) Russia				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Auser N. Schulman				
14. MOTHER'S MAIDEN NAME Ida Sundell					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW 1				
16. SOCIAL SECURITY NO. 544-1-1					17. INFORMANT Clinical Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE DILATATION OF THE STOMACH 544-1-1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) ANAPLASTIC ADENOCARCINOMA OF THE STOMACH WITH METASTASIS TO PERIGASTRIC, PARI-PANCREATIC, PERAORTIC, MEDIASTINAL AND CERVICAL LYMPH NODES AND THYROID (c) MEDIASTINAL AND CERVICAL LYMPH NODES AND THYROID					INTERVAL BETWEEN ONSET AND DEATH 5 hours 1 1/2 Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 5, 1960 , to Dec. 26, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 26, 1960 , and that death occurred at 1 P.M. , from the causes and on the date stated above.					22a. SIGNATURE FREDERICK S. DONALDSON, M.D.				
22b. DATE SIGNED 12/27/60					22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				
22d. ADDRESS VAH, Fort Howard, Md.					23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				
23b. DATE THEREOF 12-28-60					23c. NAME OF CEMETERY OR CREMATORY Mishaan Israel Congregation				
23d. LOCATION (City, town or county) (State) Southern Ave., Balto., Md.					24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BRO				
25a. REC'D BY REGISTRAR JAN 3 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

18008

13581

Valley was established in 1901
North Street, New York
21 days

LOUIS
Schulman
Dec. 10, 1901

Josephine
Schulman
Dec. 10, 1901

Valley was established in 1901
North Street, New York
21 days

Valley was established in 1901
North Street, New York
21 days

Valley was established in 1901
North Street, New York
21 days

Valley was established in 1901
North Street, New York
21 days

Valley was established in 1901
North Street, New York
21 days

Valley was established in 1901
North Street, New York
21 days

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
13608
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13582

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmondson Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 1708 Hill Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J. Middle LOYD Last SHAFFER, SR.		4. DATE OF DEATH Month Dec. Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1894
9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Vet. Administration	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew C. Shaffer		14. MOTHER'S MAIDEN NAME Alice Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I None	
17. INFORMANT Mr. J. Lloyd Shaffer, Jr.-1708 Hill Drive #7		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO ARTERIOSCLEROTIC CV DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 6 YRS DUE TO (c) 6 YRS		INTERVAL BETWEEN ONSET AND DEATH 2 WKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY OCCLUSION. CARCINOMA BLADDER		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APR. 1948 to DEC. 2, 1960 , that (I) (we) last saw the deceased alive on DEC. 2, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John F. Schaefer MD		22b. DATE SIGNED 12/2/60	
22c. PHYSICIAN'S NAME (Type) John F. Schaefer, M. D.		22d. ADDRESS 401 Random Rd. Balto. 29, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/8/60	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Parsons, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor		25a. REC'D BY REGISTRAR DEC 6 '60	
ADDRESS Balto - 17, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

133004

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

1904

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13609

CERTIFICATE OF DEATH

13583

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 213 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Westmoreland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colonial Beach d. STREET ADDRESS 208 Mimosa Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ERNEST SMALLING				4. DATE OF DEATH Month Day Year December 9 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 28, 1900	
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Sullivan Co., Tennessee	
13. FATHER'S NAME John E. Smalling				14. MOTHER'S MAIDEN NAME Florence Ora Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 167-20-1586		17. INFORMANT Clinical Records VA Hospital, Baltimore 18, Maryland, Ft. Howard Div. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 053.1 DUE TO STAPHYLOCOCCUS AUREUS Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psoas Abscesses, Bilateral. Tuberculosis of Spine, L-4 L-5, Active.							INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 10 1960 to December 9 1960 , that (I) (we) last saw the deceased alive on December 9 1960 , and that death occurred at 9:40 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/9/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, Baltimore 18, Md. FORT Howard, Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Dec. 13/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arl. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson				ADDRESS 1300 N 38th N.W.		25a. REC'D BY REGISTRAR DEC 12 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

Hyson Funeral Home, 1300 N Street, N.W., Washington, D.C.

16523
13603

ARLINGTON NATIONAL CEM.
ARL - VA.

Dec. 13/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13610 CERTIFICATE OF DEATH

13584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>			c. LENGTH OF STAY IN lb <u>1 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Nursing Home</u>				d. STREET ADDRESS <u>849 W. University Pkwy.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wiley</u> Middle <u>Winthrop</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>01</u> Hours <u>4</u> Min.	IF UNDER 24 HRS. Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Milton Smith</u>				14. MOTHER'S MAIDEN NAME <u>Ann Spralls</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-38-7356</u>		INFORMANT <u>Mrs. Helen F. Smith-849 W. University Parkway</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>Dec 60</u> , that I last saw the deceased alive on <u>21 Dec 60</u> and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William J. Helfrich</u>		M.D. <u>5006 Roland Ave</u>		ADDRESS (Street, city or town, state) <u>Baltimore 10, Md</u>		DATE SIGNED <u>12-23-60</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tuckner & Sons</u>				ADDRESS <u>Balto 17 Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John Robert Carter

1907

John Robert Carter

1907

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13611

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13585

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		d. STREET ADDRESS <u>1925 ROCKWELL AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1925 ROCKWELL AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MOLLIE First Middle Last FREDERICKA SORENSEN</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 8, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>18</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY GEISER</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FRED. SORENSEN</u>		Address <u>1925 ROCKWELL AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertension & arteriosclerosis</u> DUE TO (c) <u>10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Oct 18, 1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthenol. cardiovascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1957</u> to <u>Oct 23, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 22, 1960</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Justinas Kudirka</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Justinas KUDIRKA</u>		22d. ADDRESS <u>1709 Edmonstone Ave, Catonsville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-27-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOYDON PARK</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE L. SCHWAB</u>		25a. REC'D BY REGISTRAR <u>Francis W. Miller</u>	
25b. REGISTRAR'S SIGNATURE <u>2101 Frederick Ave.</u>		25c. DATE <u>DEC 27 '60</u>	

RECEIVED

1861

1

CERTIFICATE OF DEATH

Reg. Dist. No. 13586

13612

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hosp.</u>				d. STREET ADDRESS <u>3406 39th Pl.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Amy</u> Last <u>Stowe</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-71</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Robert S. Sutton</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Spring Grove State Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aneurysm; thoracic aorta</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				(County) <u> </u>		(State) <u> </u>	
21. I certify that I attended the deceased from <u>10-18-</u> , 19 <u>60</u> , to <u>12-18-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-18-</u> , 19 <u>60</u> , and that death occurred at <u>5:45 p.m.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Stella Wachslar</u>				DATE SIGNED <u>12-19-60</u>			
ACTUAL SIGNATURE <u>Stella Wachslar</u>				M.D. <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M.D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. James Co.</u>				ADDRESS <u>Wash. DC</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12002

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF BIRTH		CITY		STATE		COUNTRY		DATE OF BIRTH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		DATE OF MARRIAGE	
PREVAILING DISEASE		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

13613

CERTIFICATE OF DEATH

Reg. Dist. No.

13587

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Shadybrook Ave</u>				d. STREET ADDRESS <u>15 Shadybrook Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry W. Sweet</u>				4. DATE OF DEATH Month Day Year <u>Dec. 21 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/24/08</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lathe Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hickey Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Sweet</u>				14. MOTHER'S MAIDEN NAME <u>Grace Laugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs Ida V. Sweet</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>ACUTE CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROSIS - DIABETES</u> (c) <u>HYPERTENSION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1/1</u> , 19 <u>60</u> , to <u>12/21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/21</u> , 19 <u>60</u> , and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.				ADDRESS <u>5800 Edmondson Ave</u> DATE SIGNED <u>12/21/60</u>			
PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>				ADDRESS <u>5800 Edmondson Ave</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall & Son Co</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G278 1-3-61 et

13614

CERTIFICATE OF DEATH

Reg. Dist. No.

13588

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>				c. LENGTH OF STAY IN 1b <u>96yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Middletown Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Talbott</u> Last <u>Talbott</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1864</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Talbott</u>				14. MOTHER'S MAIDEN NAME <u>Susan Daley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Dr. Clarence Spicer</u>				Address <u>Parkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> to <u>Dec 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>60</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milner Bortner</u>				ADDRESS (Street, city or town, state) <u>White Hall, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Milner Bortner</u>				DATE SIGNED <u>12/26/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		22d. LOCATION (City, town, or county) <u>York, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kautenstein</u>				ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u></u>	
24b. REGISTRAR'S SIGNATURE <u></u>				DATE <u>DEC 30 '60</u>			

13322

CERTIFICATE OF DEATH

13322

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

12 1
FOR STATE
HEALTH DEPT.

MD. STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13589

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>52</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1 Munnery Lane</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> d. STREET ADDRESS <u>1 Munnery Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Nathan Louis Teitelbaum</u>			4. DATE OF DEATH <u>Dec. 4, 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 15, 1898</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Pinus Teitelbaum</u>			
14. MOTHER'S MAIDEN NAME <u>Anna ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>			
16. SOCIAL SECURITY NO. <u>420.1</u>		17. INFORMANT <u>Bertha Teitelbaum 1 Munnery Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY <u>19</u> Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u>Balto</u>		20g. (County) <u>Md</u>		20h. (State) <u>Balto</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>	
22d. FUNERAL DIRECTOR <u>Jack Lewis</u>		ADDRESS <u>2100 Eutaw Pl</u>		22e. LOCATION (City, town, or country) <u>Balto Md</u>	
22f. REC'D BY REGISTRAR <u>DEC 6 '60</u>		22g. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

18003

1901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1901

DEATH CERTIFICATE

1

James H. McNeill
James H. McNeill

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

050

2

000

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13616 CERTIFICATE OF DEATH 13590											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				0260-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 1007 Crain Highway, S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL C TEPPER						4. DATE OF DEATH December 30 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (County & State, or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Tepper						14. MOTHER'S MAIDEN NAME Augusta Knapp					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1				16. SOCIAL SECURITY NO. 220-36-0017		17. INFORMANT Clinical Records Address VAH Baltimore 18 Md-FORT HOWARD DIVISION					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION LEFT ANTERIOR DESCENDING BRANCH AND RIGHT CORONARY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) MYOCARDIAL INFARCTIONS (c) BRONCHOPNEUMONIA CALCIFIC AORTIC STENOSIS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS UNKNOWN 2 MONTHS UNKNOWN 4 DAYS UNKNOWN											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 28 3 15 60 to Dec. 30 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 30 19 60 , and that death occurred at 3 15 M, from the causes and on the date stated above.											
22a. SIGNATURE Arthur T. Faulk						M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.						22d. ADDRESS VAH, Fort Howard, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/61		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park, Inc.				23d. LOCATION (City, town or county) (State) Glen Burnie Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley				ADDRESS 421 Crain Highway Glen Burnie, Maryland				25a. REC'D BY REGISTRAR JAN 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

13710

13710

11

2. 10. 1958
1. 10. 1958
9. 10. 1958
1. 10. 1958
1. 10. 1958
1. 10. 1958

COAST GUARD VESSEL
NO. 1000
NO. 1000
NO. 1000
NO. 1000
NO. 1000
NO. 1000

10

10

10

10

10

10

10

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

VR A15 (4)
15M 9/59

1
13618
13592
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSBORNE Middle L. Last THOMPSON		4. DATE OF DEATH Month December Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (State or foreign country) Centreville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lloyd Thompson		14. MOTHER'S MAIDEN NAME Elsa Chase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-24-3395	
17. INFORMANT Clinical Records		Address VAH, Baltimore 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) NEPHROSCLEROSIS DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cysts of the Liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 21, 1960 to Dec. 24, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 24, 1960 and that death occurred at P. M. , from the causes and on the date stated above.			
22a. SIGNATURE Lawrence D. Marcus		22b. DATE SIGNED 12/25/60	
22c. PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS, M.D.		22d. ADDRESS VAH, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 28-60	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Centresville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE CHARLES HICKS, 3rd.		25a. REC'D BY REGISTRAR 24 W. All Saints St. Frederick, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE JAN 4- '61	

18208

CERTIFICATE OF DEATH

18218

II

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

CAUSE OF DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

NAME

SEX

EDUCATION

DATE

PLACE

DATE OF BIRTH

PLACE OF BIRTH

NAME

SEX

RELIGION

EDUCATION

DATE OF DEATH

PLACE OF DEATH

NAME

SEX

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 4 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1561 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13591

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pulaski Highway		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood		d. STREET ADDRESS Bauer Tr. Pk.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Route #40				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM Henry THOMPSON				4. DATE OF DEATH December 28 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1912	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Keeper		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Slate Hill, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elwood Thompson				14. MOTHER'S MAIDEN NAME Pearl Weil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-22-0038		17. INFORMANT (Wife) Evelyn Duff Thompson Address Box 137 Edgewood, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Occlusion. DUE TO (c) XXXXX						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED December 29, 1960			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/1960		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or country) (State) Bel Air, Harf.co., Md.	
23. FUNERAL DIRECTOR Joseph W. Foster				ADDRESS W. Broadway & Williams			
				24a. REC'D BY REGISTRAR JAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hawk	

1941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

HAWAII

Living

DECEASED

Wounded

Other

Age

U.S. Service No.

1941

WATSON

Henry

ATLANTA

0001 01 1911 48

White

Male

U.S.A.

Olivia Service State Hill, Tenn.

Paul Henry

Paul Hill

Olivia Thompson

Box 137

1911

00-0000 Valyn Hill Thompson, 1911

1911-0000 Valyn Hill Thompson, 1911

Coroner's selection.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>M</div> <div>X</div> </div> </div> <div> <div> <div>1</div> <div>2</div> </div> <div> <div>VS. A15ME</div> <div>SM 7/59</div> </div> </div>												<div> <div> <div>1</div> <div>2</div> </div> <div> <div>VS. A15ME</div> <div>SM 7/59</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore County Beltway						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson 4 d. STREET ADDRESS 303 Colonial Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Oswald Kenneth Townsend						4. DATE OF DEATH Month December Day 13 Year 1960																	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1897		9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Ship Building		11. BIRTHPLACE (State or foreign country) Staten Island, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13. FATHER'S NAME William S. Townsend						14. MOTHER'S MAIDEN NAME Lillian M. Walters																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES W W I				16. SOCIAL SECURITY NO. 217-07-4339		17. INFORMANT Annie Laurie Townsend, 303 Colonial Court, Address																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DU TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 years DU TO (c)												INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>																	
EXAMINER'S NAME (Type) Charles F. O'Donnell						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 12/13/60																	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12-15-60		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md															
23. FUNERAL DIRECTOR Wm. Cook-Townson, Inc., 1050 York Road, Towson 4 ADDRESS						24a. REC'D BY REGISTRAR DEC 15 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Hume															

1881, 25. 1882

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13620
CERTIFICATE OF DEATH

13594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>71 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Powers Avenue</u>				d. STREET ADDRESS <u>Powers Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace Louise Tucker</u>				4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/25/1889</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Balt Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph L. Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Marie Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marie Dorsey</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>arterio sclerotic cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hour</u> <u>3 years</u> <u>and 3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1957</u> to <u>Dec</u> 19 <u>60</u> , that I last saw the deceased alive on <u>7 Dec</u> 19 <u>60</u> , and that death occurred at <u>11 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u>				DATE SIGNED <u>Cockeysville 12 Dec 60</u>			
PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>				<u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Basil Chapel</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Cockeysville Balt. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Whatum Jr.</u>				ADDRESS <u>1701 McCulloch</u>		24a. REC'D BY REGISTRAR <u>DEC 14 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13622

18596

1. NAME OF DECEASED (Type or Print) Katherine Weiss Tucker		2. DATE OF DEATH December 19, 1960	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 090 Mercy Villa (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore County		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore d. STREET ADDRESS (If rural, give location) Mercy Villa	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 6/6/66
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10. B. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 94
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Weiss		14. MOTHER'S MAIDEN NAME Emma Wimmer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Margaret Crocker-----		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X Degenerative C.V. Disease DUE TO marked arteriosclerosis DUE TO Chronic Nephritis with uremia DUE TO acute heart failure		INTERVAL BETWEEN ONSET AND DEATH 4-5 years 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
22. I certify that (I) (this hospital) attended the deceased from 19 Nov to 19 Dec 1960 that (I) (we) last saw the deceased alive on 19 Dec 1960 and that in (my) (our) opinion death occurred at 2:25 P.M. from the causes and on the date stated above.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23A. SIGNATURE Joseph E. Wimmer ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.	23B. ADDRESS 2925 N. Charles St		23C. DATE SIGNED 12/19/60
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/21/60	24C. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 21 1960		25B. NAME OF REGISTRAR John A. Moran	25C. FUNERAL DIRECTOR ADDRESS 3000 F. Baltimore St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 13621 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr10mth15dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lena Middle Isabelle Last Tucker		4. DATE OF DEATH Month December Day 19 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1885
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Massachusetts	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME XXXXXX Roy DeCoff		14. MOTHER'S MAIDEN NAME XXXXXX Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXXXXX NO		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Chronic cardiovascular disease with arteriosclerosis (b) Chronic brain syndrome associated with senile brain disease DUE TO (c) Chronic brain syndrome associated with senile brain disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 14, 19 58 , to Dec. 19, 19 60 , that I last saw the deceased alive on Dec. 19, 19 60 , and that death occurred at 12:30 a. m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED SPRING GROVE STATE HOSPITAL 12-19-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-22-60	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE BROOKS FUNERAL SERV. 622 YORK ROAD, TOWSON		24a. REC'D BY REGISTRAR DATE 12-20-60	
ADDRESS M.D. 622 YORK ROAD, TOWSON		24b. REGISTRAR'S SIGNATURE William S. Thane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THIS IS A PERMANENT RECORD.
M. OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13623

CERTIFICATE OF DEATH

14584

1. NAME OF DECEASED (Type or Print)		PHILIP H. TURNER		2. DATE OF DEATH Dec. 19, 1960	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 715 Elmwood Avenue Baltimore, 6, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS 715 Elmwood Ave.,			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 2, 1865	9. AGE (In years last birthday) 95	If Under 1 Year Months Days Hours Min.
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10. B. KIND OF BUSINESS OR INDUSTRY Baltimore Transit Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Zone 6 Algie L. Turner, son, 6001 Mannington Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 422.1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) DUE TO Congestive Heart Failure (B) DUE TO Arteriosclerotic Cardiovascular Disease (C) DUE TO Hemiplegia - L. side		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. DATE OF OPERATION Nov 29 1960		19. CONDITION FOR WHICH OPERATION WAS PERFORMED 19. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from Nov 29 1960 to Dec 19 1960 that (I) (we) last saw the deceased alive on Dec 19 1960 and that in (my) (our) opinion death occurred at 9:00 m., from the causes and on the date stated above.		23A. SIGNATURE John E. White ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23B. ADDRESS 5214 Bayridge 23C. DATE SIGNED Dec 21/60	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/22/60		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. FUNERAL DIRECTOR Charles E. Schimunek Funeral Home 3331 Brehms Lane		24F. ADDRESS	

A record of the following information should be kept on each case and set
 attached to the file. This information is subject to change as the case progresses.
 1. Name of the patient. 2. Date of birth. 3. Sex. 4. Race. 5. Religion.
 6. Education. 7. Occupation. 8. Social history. 9. Family history. 10. Present illness.
 11. Past medical history. 12. Allergies. 13. Current medications. 14. Laboratory tests.
 15. Radiology. 16. Pathology. 17. Consultations. 18. Discharge summary. 19. Follow-up.
 20. Death certificate.

1. Name of the patient: _____
 2. Date of birth: _____
 3. Sex: ☐ Male ☐ Female
 4. Race: _____
 5. Religion: _____
 6. Education: _____
 7. Occupation: _____
 8. Social history: _____
 9. Family history: _____
 10. Present illness: _____
 11. Past medical history: _____
 12. Allergies: _____
 13. Current medications: _____
 14. Laboratory tests: _____
 15. Radiology: _____
 16. Pathology: _____
 17. Consultations: _____
 18. Discharge summary: _____
 19. Follow-up: _____
 20. Death certificate: _____

CERTIFICATE OF DEATH

13024

NAME OF DECEASED <i>John A. Smith</i>		DATE OF DEATH <i>Jan 15 1902</i>
AGE <i>45</i>		SEX <i>Male</i>
RACE <i>White</i>		RELIGION <i>Methodist</i>
BIRTHPLACE <i>England</i>		RESIDENCE <i>123 Main St. Baltimore, Md.</i>
OCCUPATION <i>Engineer</i>		CAUSE OF DEATH <i>Heart Disease</i>
DISEASE OR INJURY <i>Myocarditis</i>		PERIOD OF ILLNESS <i>2 weeks</i>
PLACE OF DEATH <i>Home</i>		ATTENDING PHYSICIAN <i>Dr. J. H. Jones</i>
SIGNATURE OF DECEASED <i>(Signature)</i>		TESTIMONY OF DECEASED <i>(Signature)</i>
SIGNATURE OF NEXT OF KIN <i>(Signature)</i>		TESTIMONY OF NEXT OF KIN <i>(Signature)</i>
SIGNATURE OF PHYSICIAN <i>(Signature)</i>		TESTIMONY OF PHYSICIAN <i>(Signature)</i>
SIGNATURE OF CORONER <i>(Signature)</i>		TESTIMONY OF CORONER <i>(Signature)</i>
SIGNATURE OF JURY <i>(Signature)</i>		TESTIMONY OF JURY <i>(Signature)</i>
SIGNATURE OF JUDGE <i>(Signature)</i>		TESTIMONY OF JUDGE <i>(Signature)</i>
SIGNATURE OF CLERK <i>(Signature)</i>		TESTIMONY OF CLERK <i>(Signature)</i>
SIGNATURE OF REGISTRAR <i>(Signature)</i>		TESTIMONY OF REGISTRAR <i>(Signature)</i>
SIGNATURE OF SHERIFF <i>(Signature)</i>		TESTIMONY OF SHERIFF <i>(Signature)</i>
SIGNATURE OF TOWNSHIP CLERK <i>(Signature)</i>		TESTIMONY OF TOWNSHIP CLERK <i>(Signature)</i>
SIGNATURE OF COUNTY CLERK <i>(Signature)</i>		TESTIMONY OF COUNTY CLERK <i>(Signature)</i>
SIGNATURE OF STATE CLERK <i>(Signature)</i>		TESTIMONY OF STATE CLERK <i>(Signature)</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13625 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13598	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md b. COUNTY Balto.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN TB 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm, Md					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Blandings Estates						d. STREET ADDRESS 1508 Remmel Ave. 6 Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID RONALD VANCE						4. DATE OF DEATH December 12 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Oct 11th 1940		9. AGE (in years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mover				10b. KIND OF BUSINESS OR INDUSTRY Furniture Mover		11. BIRTHPLACE (State or foreign country) W. Va				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Donald Vance						14. MOTHER'S MAIDEN NAME Virginia Porter					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 333-60-8212		17. INFORMANT Harmon Porter 1508 Remmel Ave 6 Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication 892-9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Found in parked car							
20c. TIME OF INJURY Found 11 A.M. 12/12/60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Car		20f. (City or town) (County) (State) Baltimore Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> <u>Undetermined manner</u> <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/12/60			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/60		22c. NAME OF CEMETERY OR CREMATORY Whitmer W. Va		22d. LOCATION (City, town, or country) (State) Whitmer W. Va.					
23. FUNERAL DIRECTOR Lorraine Funeral Home				ADDRESS 7406 Belair Rd Baltimore 6 Md.		24a. REC'D BY REGISTRAR DEC 15 '60		24b. REGISTRAR'S SIGNATURE Arthur D. Hume			

STATE
HUMAN

1002

1002

1

Carry on the investigation

Found in parked car

Found in 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Found in 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

10/12/10

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 7, MARYLAND

13599

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 21 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2009 EAST PRATT STREET	
3. NAME OF DECEASED (Type or print) First HARRY Middle H Last VOHS		4. DATE OF DEATH Month DECEMBER Day 16 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 9, 1897
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10b. KIND OF BUSINESS OR INDUSTRY PACKING HOUSE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUDOLPH VOHS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 170-12-7740	
17. INFORMANT CLIN REC- VAH BALTO 18 MD- FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF LUNG WITH METASTASIS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME, ORGANIC		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from NOV. 25, 1960 to DEC. 16, 1960 that (IX) (we) last saw the deceased alive on DEC. 16, 1960 , and that death occurred at 11:30 P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles E. Rowan</i>		22b. DATE SIGNED 12-17-60	
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN M.D.		22d. ADDRESS VAH BALTIMORE 18 MD-FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE John M Weber & Sons Inc		25a. REC'D BY REGISTRAR DATE DEC 19 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>			

DECLARATION OF

STATE

DATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

STATE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13627

CERTIFICATE OF DEATH

13600

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradshaw Rd.</u>		d. STREET ADDRESS <u>Bradshaw Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Christina</u> Middle <u>Vondracek</u> Last <u></u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1877</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Bohemia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Frank Dvorak</u>		14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Charles Masek</u>		Address <u>Bradshaw Rd. Kingsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease - with myocardial failure</u> 422.1 DUE TO <u>senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> (b) <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>60</u> to <u>12/11</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12/9</u> 19 <u>60</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>D. T. Battaglia</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>D. T. Battaglia MD</u>		22d. ADDRESS <u>5829 Belair Rd Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 15, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY ADDRESS <u>Bohemian National</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Caroline Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 16 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

15000

CERTIFICATE OF DEATH

1883

NOV 05 1911
11 11 30 AM

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13628

CERTIFICATE OF DEATH

13601

Item 16 Film 62/6 12-6-60 et

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 6310 York Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Walsh		4. DATE OF DEATH Month Dec. Day 4 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/1877
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Walsh		14. MOTHER'S MAIDEN NAME Charlotte Danaher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-07-4988	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO (b) Carcinoma of Breast. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Sept. 12, 1960 to December 3, 1960 that (I) (we) last saw the deceased alive on Dec. 3, 1960 , and that death occurred at 8:49 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED 12/4/60	
22c. PHYSICIAN'S NAME (Type) Dr. Robert Mahon		22d. ADDRESS 602 E. Joppa Road Towson, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7, 1960	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co		25a. REC'D BY REGISTRAR DEC 7 '60	
ADDRESS 4905 York Road		25b. REGISTRAR'S SIGNATURE Robert S. Francis	

CERTIFICATE OF DEATH

13602

Reg. Dist. No.

13629

1. PLACE OF DEATH a. COUNTY <i>Balto Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>5</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1113 Glenwood Ave</i>		d. STREET ADDRESS <i>1113 Glenwood Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Harry Edgar Warner</i> First Middle Last		4. DATE OF DEATH <i>Dec 4</i> Month Day Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/26/82</i>
9. AGE (In years lost birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bldg. Const.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shopt.</i>	11. BIRTHPLACE (State or foreign country) <i>md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Upton Warner</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i> INFORMANT Address <i>Evelyn W. Gale</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular Hemorrhage</i> <i>434.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASC V Disease</i> DUE TO (c) <i>Congestive Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs.</i> <i>13 yrs</i> <i>recurrent</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Has had freq. "small" CVA.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept</i> , 19 <i>58</i> , to <i>Dec 4</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Dec 4</i> , 19 <i>60</i> , and that death occurred at <i>6:28 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Victor F. King</i> M.D.		DATE SIGNED <i>Townson 4, Md</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-7-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Torrance</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Co - Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Edw. A. MacNabb - 301 Fredrick Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 9 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thacker</i>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13003

CERTIFICATE OF DEATH

1862

WILLIAM A. MCGOWAN

[Faint, illegible handwritten text, likely a death certificate form with fields for name, age, sex, cause of death, etc.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13603

13445

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 15 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11715 Reisterstown Road		e. STREET ADDRESS 11715 Reisterstown Road	
3. NAME OF DECEASED (Type or print) John William Weiskittel		4. DATE OF DEATH Month Dec. Day 12 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1906
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tester of electronics	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Louis Weiskittel	
14. MOTHER'S MAIDEN NAME Sophia Rupp		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-07-8810		17. INFORMANT Mrs. Leone Weiskittel, Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - rectum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 1957 , to December 12, 1960 , that I last saw the deceased alive on December 11, 1960 , and that death occurred at 3:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence E. McWilliams		ADDRESS (Street, city or town, state) M.D. 11904 Reisterstown Rd, Reisterstown, Md.	
PHYSICIAN'S NAME (Type) Dec 12, 1960		DATE SIGNED Dec 12, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 14, 1960	22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens	22d. LOCATION (City, town, or county) (State) Finksburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE DEC 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13630
13604
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 30 1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelyn Middle Busick Last Weissenborn		4. DATE OF DEATH Month December Day 29 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 29, 1870
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Busick		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. Neilson Busick		Address Hopkins Apts.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoptotic Pneumonia 334x DUE TO Senile General & Cerebral Arteriosclerosis & (b) Myocardial Insufficiency DUE TO Myocardial Insufficiency (c) Myocardial Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/27 19 50 to 12/29 19 60 , that (I) (we) last saw the deceased alive on 12/23 19 60 , and that death occurred on 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE E. W. Johnson		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. E.W. Johnson		22d. ADDRESS 3432 Frederick Ave. Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 31, 1960	
23c. NAME OF CEMETERY OR CREMATORY Still Pond		23d. LOCATION (City, town, or county) (State) Still Pond, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR DATE JAN 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13631

CERTIFICATE OF DEATH

13605

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1830 EDMONDSON AVENUE • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ROBERT WELLS		4. DATE OF DEATH Month December Day 31 Year 1960		5. SEX MALE							
6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH January 1, 1920		9. AGE (In years last birthday) 40 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY TAILORING SHOP		11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME NEWTON WELLS			14. MOTHER'S MAIDEN NAME MURIEL SQUIRREL								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW-11		16. SOCIAL SECURITY NO. 213-12-4561		17. INFORMANT CLIN REC VAH BALTIMORE 18 MD-FT HOWARD DIV. Address _____							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC HYPERTROPHY AND DILATATION WITH CONGESTIVE FAILURE AND UREMIA 443 x DUE TO </td> <td style="width: 70%;"> INTERVAL BETWEEN ONSET AND DEATH UNKNOWN </td> </tr> <tr> <td> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO </td> <td> UNKNOWN </td> </tr> <tr> <td colspan="2"> (c) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC HYPERTROPHY AND DILATATION WITH CONGESTIVE FAILURE AND UREMIA 443 x DUE TO	INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO	UNKNOWN	(c)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC HYPERTROPHY AND DILATATION WITH CONGESTIVE FAILURE AND UREMIA 443 x DUE TO	INTERVAL BETWEEN ONSET AND DEATH UNKNOWN										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO	UNKNOWN										
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 26, 1960 to December 31, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 31, 1960 , and that death occurred at 4:55 a.m. from the causes and on the date stated above.											
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Charles Allen M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH BALTIMORE 18 MD-FT HOWARD DIVISION		22b. DATE SIGNED 12-31-60							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Jan. 4, 1961		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL							
24. FUNERAL DIRECTOR'S SIGNATURE Morton & Dyett		25a. REC'D BY REGISTRAR JAN 4 '61		25b. REGISTRAR'S SIGNATURE 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

1-1931

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave.					d. STREET ADDRESS 12200 Old Frederick Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle Weltner Last Weltner			4. DATE OF DEATH Month Dec. Day 26 Year 1960						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13, 1888		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Weltner				14. MOTHER'S MAIDEN NAME Christine Mehm					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Anna Bachman, 2200 Old Frederick Rd					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 44-3 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch. Hypertension Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-30- 1957 to 12-26- 1960 , that (I) (we) last saw the deceased alive on 12-25- 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above.									
22a. SIGNATURE William K. Gallagher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) William K. Gallagher M.D.				22d. ADDRESS 6209 Frederick Ave Balt. 28, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/60		23c. NAME OF CEMETERY OR CREMATORY Louden Park		23d. LOCATION (City, town, or county) (State) Baltimore 29 Md			
24. FUNERAL DIRECTOR'S SIGNATURE Nitzke F.D. 4101 Edmondson				ADDRESS ve		25a. REC'D BY REGISTRAR DATE DEC 28 '60		25b. REGISTRAR'S SIGNATURE Carlton S. Harris	

1

2

13632

13606

M

09

I

0

1

BP

13882

CERTIFICATE OF DEATH

13882

1

13633

CERTIFICATE OF DEATH

Reg. Dist. No.

13607

1. PLACE OF DEATH o. COUNTY Baltimore M		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home		d. STREET ADDRESS 13X-2	
3. NAME OF DECEASED (Type or print) MARGARET WHEELER		4. DATE OF DEATH Month Dec. , Day 29 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1881
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Michael A. Maloney		14. MOTHER'S MAIDEN NAME Mary E. Rogers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Ho. Co. Welfare Board, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized Arteriosclerosis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hip fracture old; Diabetes Mellitus; Fecal Impaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sept 1959	20f. (City or town) (County) (State) 12/29/60
21. I certify that I attended the deceased from Sept 1959 to 12/29/60 , that I last saw the deceased alive on 12/27/60 19 1960 , and that death occurred at 105P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W.E. McGrath		DATE SIGNED 12/30/60	
PHYSICIAN'S NAME (Type) W.E. McGrath		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28nd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-31-60	22c. NAME OF CEMETERY OR CREMATORY Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JAN 3 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



1963

STATE OF TEXAS

1963

IN SENATE,
January 15, 1963.
REPORT
OF THE
COMMISSIONER OF THE
GENERAL LAND OFFICE
TO THE
COMMISSIONERS OF THE
GENERAL LAND OFFICE
AND TO THE
SENATE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13635 CERTIFICATE OF DEATH 13609

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> 52		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Manor</u>			d. STREET ADDRESS <u>804 Frederick Ave</u>		
3. NAME OF DECEASED (Type or print) <u>Charles P. Wilson</u> First Middle Last			4. DATE OF DEATH <u>Jan 28</u> 19 <u>60</u> Month Day Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/81</u>		9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resol Chem. Co. Ret.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Columbus Wilson</u>			14. MOTHER'S MAIDEN NAME <u>Emma Barringer</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>216-05-1079</u>		
17. INFORMANT <u>Mrs Catherine Hande</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular occlusion</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic vascular disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 24</u> 19 <u>60</u> to <u>Jan 28</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Jan 24</u> 19 <u>60</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Dr. Wilson McKay</u>			22b. DATE SIGNED <u>Dec 29, 1960</u>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <u>6014 Edmondson Ave Baltimore Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/31/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ...</u> ADDRESS <u>28</u>			25a. REC'D BY REGISTRAR <u>JAN 3 '61</u> DATE		
			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

1898

1898

1

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13636
CERTIFICATE OF DEATH
13610

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 21 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. STREET ADDRESS 4407 MARBLE HALL RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle ZADOC Last WOLFE		4. DATE OF DEATH Month DEC Day 24 Year 1960	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1875 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AUTO	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM SCOTT WOLFE		14. MOTHER'S MAIDEN NAME MARGARET MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr. Address Cockeysville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-22-61 DUE TO Arterio Sclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) 2 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-1-1959 to 12-23-1960 , that (I) (we) last saw the deceased alive on 12-23-1960 , and that death occurred on 5-25-61 M, from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees M.D.		22b. DATE SIGNED 12/24/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-27-60	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DEC 27 '60 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur L. Kinnel	

19740

CERTIFICATE OF DEATH

18838

WILLIAM SCOTT
Born [illegible]
Died [illegible]
Cause of Death [illegible]
Buried [illegible]
Witnesses [illegible]
Minister of the Gospel [illegible]

[Faint, mostly illegible text, likely a continuation of the certificate or a separate document.]

[Faint, mostly illegible text at the bottom of the page, possibly a signature or footer.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

13637

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13611

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill Manor</u>		d. STREET ADDRESS <u>3401.4</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Elizabeth E. Zimmerman</u>		4. DATE OF DEATH <u>December 7th 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene Hulseman</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Richard E. Zimmerman</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease with Decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (e), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Nov. 15, 1960</u> to <u>Dec. 7, 1960</u> ; that (I) <u>(we)</u> last saw the deceased alive on <u>Nov. 22, 1960</u> , and that death occurred at <u>9:38</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William H. Kammerer, Jr. M.D.</u>		22b. DATE SIGNED <u>7 DEC 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H. Kammerer, Jr.</u>		22d. ADDRESS <u>6011 York Rd. Balto. 17, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12-10-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>DEC 9 '60</u>	
ADDRESS <u>5305 Harford Road</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	

1887

Belmore

London

281 Waterloo Road

W. & A. G. G. G.

W. & A. G. G. G.

Female & male

11-12-1887

Female & male

Female & male

Printed for the Editor

W. & A. G. G. G.

W. & A. G. G. G.

W. & A. G. G. G.

W. & A. G. G. G.

W. & A. G. G. G.